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SUPREME COURT OF THE UNITED STATES

MARK J. MILLS, MICHAEL GILL AND
WILLIAM MALAMUD,

Petitioners,

v.

RUBIE ROGERS, ABLE BOLDEN, BETTY BYBEL,
JAMES COLLERAN, DONNA HUNT,
WILLIE WADSWORTH, AND HAROLD WARNER,

Respondents.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT
OF APPEALS FOR THE FIRST CIRCUIT

BRIEF OF RESPONDENTS

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QUESTIONS PRESENTED

1. Whether this Court should find that certiorari was improvidently granted or should certify the question of the right of committed mental patients to refuse anti-psychotic medication to the Massachusetts Supreme Judicial Court, in light of a recent decision by that Court resolving similar issues on state law grounds?

2. Whether involuntarily committed mental patients, who have not been adjudicated incompetent nor deemed incapable of managing their affairs or of making their own treatment decisions, have any Constitutional right to refuse powerful mind and mood altering anti-psychotic drugs which also cause a considerable percentage of patients to suffer painful and permanent physical, intellectual, emotional and psychological adverse effects?

3. Whether the principles of federalism were violated when the Court of Appeals remanded the case to the District Court to

design creative procedural mechanisms for implementing and protecting patients' right to refuse treatment, in light of the Court of Appeals' finding that the defendants' drug practices violated patients' Constitutional rights and since the Court was unable to find that the doctors' forced medication procedures were Constitutionally sufficient?

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Cleveland Board of Education v. Lafleur, 414 U.S. 632, 94 S.Ct. 791, 39 L. Ed. 2d 52 (1972)..... 81, 113

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Dale v. Hahn, 440 F. 2d. 633 (2nd Cir. 1971)..... 96

Cases Pages

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Fazio v. Fazio, Mass. Adv. Sh. (1980) 1539, 378 N.E. 2d 956 (1978)..... 70

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Harper v. Cserr, 544 F. 2d 1121 (1st Cir. 1976)..... 110

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Knecht v. Gillman, 488 F. 2d 1136 (8th Cir. 1973)..... 43

Kusper v. Pontikes, 414 U.S. 51, 94 S. Ct. 303, 38 L. Ed. 2d 260 (1973)..... 121

Lane v. Candura, 1978 Mass. App. Ct. Adv. Sh. 588, 376 N.E. 2d 1232 (1978)..... 76, 137

Leggate v. Clark, 111 Mass. 308 (1873)..... 70

Mackey v. Procunier, 477 F. 2d 877, (9th Cir. 1973)..... 43

Mathews v. Eldridge, 424 U.S. 319, 96 S. Ct. 893, 47 L. Ed. 2d. 18 (1976)..... 95, 124, 126

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Meyer v. Nebraska, 262 U.S. 390, 43 S. Ct. 625, 67 L. Ed. 1042 (1923)..... 50

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Poe v. Ullman, 367 U.S. 497, 81 S. Ct. 1752, 6 L. Ed. 2d. 989 (1961)..... 49, 53

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Stanley v. Georgia, 394 U.S. 557, 89 S. Ct. 1243, 22 L. Ed. 2d 542 (1966)..... 58

Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E. 2d 417 (Mass. 1978).....44, 47, 52, 103, 105, 106, 139

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MEDICAL AUTHORITIES

American Psychiatric Association, "Position Statement on the Right to Adequate Care and Treatment for the Men-tally Ill and Mentally Retarded," in 134 Amer. J. of Psychiat. (March, 1977). 140

Appelbaum and Gutheil, "Drug Refusal: A Study Of Psychiatric Inpatients," 137 Amer. J. Psychiat. 340, 345 (1980) 136, 140

Baldessarini, Lipinski, "Risks and Benefits of Anti-psychotic Drugs," 298 New England J. of Medicine, 427 (1973). 13, 15, 16, 17

Bochoven and Solomon, "Comparison of Two Five Year Follow-Up Studies, 1947 to 1952 and 1967 to 1972," 132 Amer. J. of Psychiat. (August, 1975). 33

Carpenter, McGlashan, Strauss, "Treatment of Acute Schizophrenia Without Drugs: An Investigation of Some Current Assumptions," 132 Amer. J. Psychiat. (August, 1975). 35

Crane, "Clinical Psychopharm-acology in its 20th Year," 181 Science (July, 1973). 34

Crane, "Two Decades of Psychopharmacology and Community Mental Health: Old and New Problems of the Schizophrenic Patient, "Transactions of the NY Acad. of Sci., Series II, Vol. 36 (1974). 15, 18, 19, 24, 28, 33, 141

Davis and Cole, "Anti Psychotic Drugs," 5 American Handbook of Psychiatry 441 (S. Averti 2nd. ed. 1975). 19

DiMascio, "Behavioral Toxicity," "The Clinical Handbook of Psychopharmacology, DiMascio and Shader, ed. (Science House, NY, 1970). 19, 30

DiMascio, Giller, Shader, "Behavioral Toxicity of Psychotrophic Drugs: III Effects on Perceptual and Causative Functions; IV Effects on Emotional (Mood) States," Connecticut Medicine (Oct., 1968). 26, 27, 28, 30

DiMascio, Shader, Harmatz, "Behavioral Toxicity of Psychotropic Drugs: V. Effects on Gross Behavior Patterns," Connecticut Medicine, Vol. 33, No. 4 (April, 1969). 26

Gardos, Cole, "Maintenance Antipsychotic Therapy: Is the Cure Worse than the Disease," 133 Amer. J. of Psychiat., 1 (January, 1976). 32

Greenblatt, Shader, DiMascio, "Extrapyramidal Side Effects of Psychotropic Drugs," Connecticut Medicine, Vol. 33, No. 3 (March, 1969). 21, 23

Klawans, "The Pharmacology of Tardive Dyskinesia," 130 Amer. J. of Psychiat., 82 (1973). 16, 23

Ludwig, Symposium, "Active Treatment of the Chronic Schizophrenic," U. S. Government Printing Office, #0-544-464-719 (1974). 22

Mills, Mark, "The Right of Involuntary Patients to Refuse Pharmacotherapy: What is Reasonable?, 8 Bull of American Academy Psychiatry and Law 313 (1981). 132, 142

Prien and Caffey, "Guidelines for Antipsychotic Drug Use," The Veterans Administration Central Neuropsychiatric Research Laboratory, Research Report No. 95 (May, 1974). 28, 33

Prien, "Symposium, Active Treatment of Chronic Schizophrenic," U.S. Government Printing Office 0-544-464-719 (1974). 28

Roth, "A Commitment Law for Patients, Doctors, and Lawyers," 136 American Journal of Psychiatry 1121 (Sept. 1979). 100

Schmidt and Jacob, "Persistent Dyskinesias Following Phenothiazine Therapy," Archives of Neurology, Vol. 14 (1966). 22

Sovner, DiMascio, Berkowitz, Randolph, "Tardive Dyskinesia and Informed Consent," Psychosomatics, Vol. 19, No. 3 (March, 1978). 13, 15 16-18, 21, 91

Van Putten, Crumpton, Yale, "Drug Refusal in Schizophrenia and the Wish to be Crazy," 33 Arch. of Gen. Psychiat., 1443 (December, 1976). 25

Van Putten, "Why Do Schizophrenic Patients Refuse to Take Their Drugs," 31 Arch. of Gen. Psychiat. (July, 1974). 29, 78

Van Putten and May, "Subjective Response as a Predicator of Outcome in Pharmacotherapy: The Consumer Has a Point," 35 Arch of Gen. Psychiat. 78

Yang and Guillan, "Sudden Death Syndrome," Journal of Kansas Medical Society 547 (Oct. 1979). 24

Other Authorities

American Bar Foundation, The Mental Disabled and the Law,, (252-255) (S. Brakel and R. Rock eds., rev. ed. 1971). 74

Brooks, "The Constitutional Right to Refuse Antipsychotic Medication," 8 Bull. American Academy Psychiat. Law 179 (1981). 27, 136

Comment, "Madness and Medicine: The Forcible Administration of Psychotropic Drugs, 487 Wisconsin Law Review 497 (1980). 27

Developments in the Law--Civil Commitment of the Mentally Ill," 87 Harvard Law Review 1190 (April, 1974). 47, 74, 75, 80, 84, 113

Gaughn and LaRue, "The Right of a Mental Patient to Refuse Drugs in an Institution," 4 Law and Psychology Review 43 (1978). 20

Harper and James, The Law of Torts 61 (1968 Supp.). 48

Massachusetts Probate Court, Rule 29B 103

Opinion of the Attorney General, February 9, 1966. 70, 76

Plotkin, "Limiting the Therapeutic Orgy, Mental Patients Right to Refuse," 72 N.W.U. L. Rev. 461 (1977). 74

STATEMENT OF THE CASE

On April 27, 1975, seven patients at the May and Austin Units of Boston State Hospital filed a civil rights class action, pursuant to 42 U.S.C. 1983, in the United States District Court of Massachusetts. The patients' sought to restrain the defendant-doctors' practice of involuntarily secluding and drugging both voluntary and involuntarily committed inpatients in their units of Boston State Hospital in non-emergencies. The plaintiffs also sought to recover compensatory damages from those responsible for that treatment. (App. at p. 45a, 48a).

On April 30, 1975 a temporary restraining order (T.R.O.) was granted pending a hearing on whether a preliminary injunction should issue, scheduled for May 8, 1975. On May 8th, the doctors assented to an extension of the T.R.O. "until a hearing on the preliminary or permanent injunction". (App. at p. 1, 48a-49a).

A merged trial on injunctive, liability and damage issues began on December 8, 1977 and concluded on Janaury 31, 1979, involving seventy-two days of trial, more than 8000 pages of transcripts, fifty witnesses, most of them psychologists, psychiatrists and other professionals, and over 2,300 pages of post-trial briefs. (App. at p. 48a-50a.) On October 29, 1979, the District Court issued an order and decision granting the patients' requested injunctive relief on both their medication and seclusion claims while denying the patients' damage claims.

The defendant-doctors did not appeal the seclusion injunctive portion of the District Court order. (App. at p. 33a.) They did appeal the medication injunctive portion of the District Court's decision to the United States Court of Appeals for the First Circuit. On November 25, 1980 the Court of Appeals issued a unanimous decision, substantially affirming the District Court's

injunctive order but modifying certain aspects of the District Court's decision. (App. at p. 3a.)

On February 20th, 1981 the defendant-doctors sought certiorari from the Court of Appeals' decision as it applies to involuntarily committed patients. They did not appeal the order and judgment as it concerns voluntarily admitted patients. On April 20th, 1981, this Court granted the defendants' petition for a writ of certiorari.

I BOTH THE DISTRICT COURT AND THE COURT OF APPEALS FOUND THAT THERE IS A CONSTITUTIONAL BASIS FOR THE RIGHT TO REFUSE.

Both the District Court and the Court of Appeals agreed that a patient has a substantial interest in refusing anti-psychotic drug treatment. The District Court relied on both the Constitutional right to privacy and the First Amendment for its ruling. (App. at p. 87a-92a.)

The Court of Appeals also held that

patients had a Constitutional right to refuse, but based its ruling on the penumbra of the due process clause of the Fourteenth Amendment, which protects each citizen's right to privacy, bodily integrity, and personal security. (App. at p. 5a.)

II BOTH THE DISTRICT COURT AND THE COURT OF APPEALS REVIEWED THE STATE INTERESTS IN FORCED MEDICATION.

A. The Power to Forcibly Medicate Under the Police Power

In recognition of both the strong state and patient interests involved in the decision of whether or not to use forced medication to prevent violence, the Court of Appeals held that a doctor may administer anti-psychotic drugs under the police power as a

> result of a determination that the need to prevent violence in a particular situation outweighs the possibility of harm to the medicated individual. . . Additionally reasonable alternatives to the administration of anti-psychotic drugs must be ruled out. . .
>
> (App. at p. 14a.)

B. The Power to Forcibly Medicate Under the Parens Patriae Power

Relying on Massachusetts statutes, regulations and judicial precedents the District Court and Court of Appeals held that an involuntary patient had to be specifically adjudicated incompetent by a court in order to treat him against his will. (App. at p. 16a-26a, 73a-75a.)

The Court of Appeals stated that if, during the period of delay in judicial action, the failure to medicate would cause the patient to significantly deteriorate, the doctors may forcibly medicate the patient. (App. at p. 24a-26a.)

C. The Court of Appeals Remanded the Case to the District Court.

The Court of Appeals remanded the case to the District Court to develop workable, Constitutionally valid procedural safeguards for patients' rights as well as to provide more specificity for the standards to regulate forced medication set out by the Court

of Appeals. (App. at p. 38a.)

On December 18, 1980 the District Court set an expedited schedule to comply with the Court of Appeals' remand order. At the hearing the defendants argued that the District Court order was totally vacated, which would have left patients without any protection pending a new decision by the District Court. (App. at p. 167a-180a.) The District Court read the Court of Appeals' decision to mean that as long as the term 'substantial likelihood' in its order was not used to mean a probability, the language "substantial likelihood" was consistent with the Court of Appeals decision. (App. at p. 178a.) The doctors filed a Motion to Clarify the order from the Court of Appeals in order to have the District Court's interim order vacated. The Court of Appeals refused to grant the motion citing to the District Court's expedited schedule for briefs and proposals. (App. at p. 164a-165a.) In

February 1981 the District Court issued an order staying the remand proceedings until this Court addressed whether it would grant certiorari. The stay was continued once certiorari was granted.

STATEMENT OF THE FACTS

I THE PLAINTIFFS WERE INVOLUNTARILY MEDICATED IN CIRCUMSTANCES THAT DID NOT CONSTITUTE AN EMERGENCY.

The District Court found that prior to April 1975, when the District Court issued its temporary restraining order (TRO), the practice of the hospital units in question was to forcibly medicate both legally and functionally competent patients who refused to take the prescribed anti-psychotic drug where there was not a "substantial likelihood of personal injury to the subject patient, to the other patients or staff members."[1] (App.

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[1]The plaintiffs never opposed the use of anti-psychotic drugs for those who participated in and competently consented to their treatment. They sought only substantive and procedural protections for its

at p. 60.) (See also App. at p. 48, 49, 71, 74.) (PF #161-225). (App. at p. 137-163.)[2]

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forced use, because of the high risk of potential harm, the extent of its intrusiveness, and the limitations of its benefits, especially when used involuntarily. When patients were provided the right to refuse and doctors were required to seek the cooperation of patients, most patients agreed to submit to some form of medication, although not necessarily the medication the doctor originally prescribed. The District Court's TRO required the doctors to listen to and to respond to the patients' complaints about the pain and discomfort caused by the medication unlike the doctors' previous practice. (PF #92-96, 223-225). (App. at p. 107-108, 162-163). An example of this change of practice was typified by the case of the named plaintiff Ruby Rogers. (See PF # 11-16, 90-169.) (App. at p. 249-250, 335-350.)

[2]A shocking illustration of the context in which forced medication occured prior to the District Court's order was testified to by a staff member, Elizabeth Franceen. Ms. Franceen described the circumstances surrounding the forcible medication of a newly admitted patient whom she had observed. The patient, somewhat agitated upon admission, was being evaluated at the admission room of the Austin Unit. She requested that she not be medicated or locked up as a condition of her hospitalization. Once the admitting doctor assured her she would not be involuntarily medicated or locked up, she relaxed and apologized for her initial agitation. A few minutes later, she was dragged by a number of mental health aides to the unit seclusion room, held down, jabbed with a hypodermic needle that broke in her buttocks, reinjected with medication from another needle and then secluded. (See PF #190). (App. at p. 148-149.)

II THE PROFOUND IMPACT AND INTRUSIVENESS OF ANTI-PSYCHOTIC DRUGS IS WELL ESTABLISHED.

There are "few legitimate medical procedures which are more intrusive than the forcible injection of anti-psychotic medication." In the Matter of Guardianship of Richard Roe, III, 1981 Mass. Adv. Sh. 981, at 1003 (Mass. 1981). Because these drugs have a profound effect on the thought processes and personality of a patient, and in recognition of their well established potential for

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The sheer humiliation suffered by that patient is not unique. Some of the defendant-doctors admitted that patients in the May Unit generally fear hypodermic needles and the procedure for forcibly medicating them. Furthermore, the intramuscular injection of anti-psychotics is extremely painful. (See PF at 249.) (App. at p. 171.)

In addition, forcible medication often made patients feel demeaned and humiliated, when they were physically restrained, had their pants removed, then injected with anti-psychotic drugs through a hypodermic needle in the buttocks, at times in full view of other patients or staff of the opposite sex. (App. at 96a-98a.) (See PF No. 248.) (App. at p. 170-171.)

causing severe and irreversible side effects, anti-psychotic drugs are now considered so intrusive and dangerous that in Massachusetts the law requires that they are equated with and treated "in the same manner" as "psychosurgery or electro-convulsive therapy." In the Matter of Guardianship of Richard Roe, III, supra at p. 1003.

> "Anti-psychotics pose a serious and significant health hazard to patients. Although... the intended effects of anti-psychotic drugs are extreme, their unintended effects are frequently devastating and often irreversible." Roe, supra, at p. 1005.

A. Anti-psychotic Drugs Cause Serious And At Times Disabling Physical And Neurological Side Effects.

The administration of any anti-psychotic drug may cause numerous serious, painful and disabling physical and neurological side effects considered adverse to the health of the patient and undesirable in regard to the intended therapeutic or beneficial effect of the medication.

The most disturbing neurological effect caused by anti-psychotic drugs is tardive dyskinesia, a deforming, often irreversible syndrome whose etiology is unknown. Rogers v. Okin, 478 F. Supp. 1342, 1360 (D. Mass. 1979) (App. at p. 69a-71a); (See generally PF # 14-40, 94-97); (App. at p. 81-82, 108, 113). See Sovner, DiMascio, Berkowitz, Randolph, "Tardive Dyskinesia and Informed Consent," Psychosomatics, Vol. 19, No. 3 (March, 1978). (App. at p. 69a-70a, fn, 5, 6, 7.) (PF # 16.) (App. at p. 81.) (The article was plaintiffs' Exhibit #31.) (hereinafter "Sovner, et al.) See also Baldessarini and Lipinski; "Risks vs. Benefits of Anti-Psychotic Drugs," 289 New England J. Med. 427, 428 (1973), (hereinafter Baldesarini and Lipinski). (PF #16.) (App. at p. 81.)

Tardive Dyskinesia manifests itself through strange, involuntary motor movements, particularly of the face, lips and tongue in

which a variety of sucking and grimacing movements occur regularly that cannot be controlled by the patient. Patients with the condition also exhibit involuntary movement of the fingers, hands, legs and pelvic area. In addition, it causes a phenomena where the tongue starts pushing against the side of the mouth. This is called "fly catcher tongue" because it looks like a frog catching flies. When the condition is fully manifested, speech can become incomprehensible, and can interfere with breathing, swallowing, and all motor activity, particularly of the arms and legs. Rogers v. Okin, supra, 478 F. Supp. at 1360 (App. at p. 69a-71a); Rogers v. Okin, 634 F. 2d 650, 653 (1st Cir. 1980.) (App. at p. 4a, 5a.) Rennie v. Klein, ____ F. 2d _____, (3rd Cir. 1981), slip op at p. 14, 15; Rennie v. Klein, 462 F. Supp. 1131, 1138 (D.N.J. 1978); Davis v. Hubbard, 506 F. Supp. 915, 928, 929 (D. Ohio 1980); In the Matter of Guardianship of Richard Roe, III,

supra, p. 1005, 1006, Goedecke v. State Department of Institutions, 603 P. 2d 123, 124 (Col. 1979); In re K.K.B., 609 P. 2d 747, 748-749 n. 3 (Okla. 1980); "Sovner, et al" supra; "Baldessarini and Lipinski, supra, at 428. The psychological effect on the patient exhibiting these bizarre, at times grotesque involuntary movements of the body can be and is often catastrophic, causing embarrassment and shame to the patient and his family, and reducing or eliminating any chance of his successful reintegration into the community. In severe cases suicide may ensue. Rogers v. Okin, supra, 478 F. Supp. at 1360 (App. at p. 69a-71a); Roe, III supra, at p. 1105, 1006; Davis v. Hubbard, supra, at p. 929. Crane, "Two Decades of Psychopharmacology and Community Mental Health: Old and New Problems of the Schizophrenic Patient," Transactions of the NY Acad. of Sci., Series II, Vol. 36 (1974) (hereinafter "Crane: Two Decades"). (PF #17, 19.) (App. at p. 82.)

Tardive dyskinesia is often irreversible. The abnormal movements may persist indefinitely after neuroleptic drug therapy is discontinued, and there is no generally effective treatment for irreversible dyskinesias. Rogers v. Okin, supra, 478 F. Supp. at 1360; Roe III, supra, at p. 1006; Davis v. Hubbard, supra, at p. 929; "Baldessarini and Lipinski", supra; Klawans, "The Pharmacology of Tardive Dyskinesia," 130 Amer. J. of Psychiat., 82 (1973) (hereinafter "Klawans"); "Sovner, et al.," supra. (PF #16.) (App. at p. 81, 82.)

Once a patient has symptoms of tardive dyskinesia, continued drug therapy may exacerbate the severity of the abnormal movements or cause them to become irreversible. "Sovner, et al." supra. (PF #31.) (App. at p. 84.)

Although all patients taking antipsychotics are potentially at risk of developing tardive dyskinesia, the syndrome

usually begins following a minimum of three months of exposure to anti-psychotic drugs. Patients receiving the drug over one year are considered a high risk to develop tardive dyskinesia. "Sovner, et. al.," supra, (PF # 24-28.) (App. at p. 83, 84.)

There is now convincing evidence that tardive dyskinesia is widespread among all patients receiving long-term neuroleptic drug therapy. In 1973 when the average prevalence of tardive dyskinesia was believed to be 15%, it was declared in the New England Journal of Medicine that "[T]he risks of iatrogenically produced chronic neurologic disability is alarming." "Baldessarini and Lipinski," supra, at 428. (PF #36.) (App. at p. 86.) Yet two recent surveys place the prevalence of tardive dyskinesia among chronically hospitalized schizophrenics at 50% and 56%. With respect to outpatients, one survey has reported a prevalence rate of 41.1%. Tardive dyskinesia is now observed in at least 30 to

50 percent of patients who have been treated with drugs for several years. Rogers v. Okin, supra, 478 F. Supp. at 1360 (App. at p. 69a-71a.); Davis v. Hubbard, supra, at p. 929; "Crane: Two Decades," supra; "Sovner, et al." supra. (PF #37, 38.) (App. at p. 86-87.)

Medical experts in Rennie v. Klein, supra, 476 F. Supp. 1294, 1300 (D.N.J. 1978) suggested that 25% to 50% of the patients in institutions in the United States have this condition.

In the case at bar, a defendants' witness, Dr. Barbara Schildkrout testified at trial that on the one ward of the Austin Unit for which she was responsible during the period from January through June of 1976, 10 to 15 patients out of a population of 70 to 75 patients had clear cases of tardive dyskinesia. TR. 41-85.

Another neurological effect caused by anti-psychotic drugs is a pseudo-parkinson

syndrome; a disorder of the central nervous system which causes tremors, stiffness, and a "mask-like face." Approximately 53% of patients on anti-psychotics experience a parkinson's-like syndrome. Rogers v. Okin, supra, 478 F. Supp. at 1360 (App. at p. 71a.) Davis v. Hubbard, supra, at p. 928; Roe III, supra,at p. 1005; DiMascio, "Behavioral Toxicity," The Clinical Handbook of Psychopharmacology, DiMascio and Shader, ed. (Science House, NY, 1970) (hereinafter "DiMascio"). (PF #49-51.) (App. at p. 89.)

Another neurological side effect of anti-psychotic drugs is characterized by physical immobility as well as lack of spontaneity and emotional indifference. Rogers v. Okin, supra, 478 F. Supp. at 1360 (App. at p. 71a); Rennie v. Klein, supra, 462 F. Supp. at 1138; "Crane: Two Decades," supra. "This effect is one of the most noticed by visitors to mental institutions." Davis v. Hubbard, supra, at p. 928; Davis and Cole,

"Anti-psychotic Drugs," in 5 American Handbook of Psychiatry, 441, 461 (S. Averti 2nd ed. 1975). Though the extent of drowsiness and sedation caused by the drugs vary, "it may lead to 'severe distress' as a consequence of the patient's desire to feel 'wide awake' and 'to think more clearly.'" Davis v. Hubbard, supra, at p. 923; Gaughn and LaRue, "The Right of a Mental Patient to Refuse Drugs In An Institution," 4 Law and Psych. Rev. 43, 51 (1978). (See PF #51-53.) (App. at p. 89, 90, 108-109.)

Persons taking anti-psychotics have also experienced a neurological reaction called dystonia. Its manifestations include spasmodic muscle reaction, such as twisting and spasms of the neck, eyes, arms and the facial muscles, arching of the back, writhing and grimacing movements, protrustion of the tongue and spastic movements of the various muscles of the body. Dystonia can be painful or very uncomfortable to patients experiencing

it. Rogers v. Okin, supra, 478 F. Supp. at 1360 (App. at p. 71a); Roe III, supra, at p. 1005; "Sovner, et al," supra, at p. 173. (PF # 54-57a.) (App. at p. 90-91, 108-109.)

Akathisia is another neurological syndrome experienced by patients administered anti-psychotic drugs. Akathisia has been described as the "itching foot syndrome." Akathisia is the inability to sit down or to stand still in one place. In addition the patient feels an inner restlessness and an irresistable desire to keep walking or tapping the feet. Even though akathisia is reversible, it is one of the most resistent to treatment. Approximately 12.5% to 21.2% of patients on anti-psychotic drugs experience akathisia. Rogers v. Okin, supra, 478 F. Supp. at 1360 (App. at p. 71a); Davis v. Hubbard, supra, at p. 928; Rennie v. Klein, supra, 462 F. Supp. at 1138; Greenblatt, Shader, DiMascio, "Extrapyramidal Side Effects of Psychotropic Drugs,"

Connecticut Medicine, Vol. 33, No. 3 (March, 1969) (hereinafter "Greenblatt, Shader, DiMascio"); Schmidt and Jacob, "Persistent Dyskinesias Following Phenothiazine Therapy," Archives of Neurology, Vol. 14 (1966) (hereinafter "Schmidt and Jacob"); Ludwig, Symposium, "Active Treatment of the Chronic Schizophrenic," U.S. Government Printing Office, #0-544-464-719 (1974) (hereinafter "Ludwig"). (PF #41-48.) (App. at p. 87, 88, 108-109.)

"Antiparkinsonian" drugs are of some value in alleviating dystonias and the rigidity of the parkinsonian reaction. But antiparkinson medication will provide patients only partial relief of these drug-induced side effects, with some patients finding no relief at all. The antiparkinsonian drugs often fail to produce remission of the symptoms of akathisia, and the parkinsonian tremor. Antiparkinson drugs also cause toxic reactions and "mental symptoms" of its own.

Some toxic effects include blurred vision, constipation, and gastrointestinal disturbances. There is also some recent evidence developed that antiparkinson drugs may diminish the value of antipsychotic drug therapy. (PF #58-61.) (App. at p. 91-92); Davis v. Hubbard, supra, at 928, Rennie v. Klein, supra, 462 F. Supp. at 1138; "Greenblatt, Shader, DiMascio," supra. In addition, antiparkinsons increase the intensity and duration of tardive dyskinesia in any patient who is prone to develop this type of abnormal movement. "Klawans," supra. (PF # 61.) (App. at p. 91-92.)

Since dystonia. akathisia and pseudoparkinsonism can be as disabling as tardive dyskinesia and can occur with equal and greater frequency, medical experts have stated that the excessive reliance on antipsychotics on the part of the medical community is as much a problem as the fact that these drugs are dangerous over the long term.

Rennie v. Klein, supra, 476 F. Supp. at 1299; "Crane: Two Decades", supra. (PF # 40.) (App. at p. 87.)

Besides the nervous system, the cardiovascular organs are the most vulnerable to anti-psychotics. There is sufficient evidence to indicate that electrocardiographic changes caused by anti-psychotics are the forerunners of permanent and often lethal cardiac complications. Roe III, supra, at p. 1005, Davis v. Hubbard, supra, at p. 928, Yang and Guillan, "Sudden Death Syndrome," J. of Kansas Medical Society, 547 (Oct. 1979). "Crane: Two Decades," supra. (PF #70.) (App. at p. 95-96, 108-109.)

There are also numerous other non-muscular side effects caused by anti-psychotics agents. These adverse responses to anti-psychotics include temporary lowering of blood pressure, dizziness, fainting, fatigue, blurred vision, weight gain, dryness of the mouth and throat, loss of libido drive,

frigidity, constipation, diarrhea, palpitations, skin rashes, and skin discoloration. (PF #86, 87.) (App. at p. 105-106, 108-109.) Rennie v. Klein, supra, 462 F. Supp. at 1138; Roe III, supra, at p. 1005, Davis v. Hubbard, supra, at p. 928; In Re K.K.B., supra, at p. 748, 749 n. 3.

B. Anti-psychotic Medications Are Also Powerful And Potentially Mind And Mood Altering Drugs.

Since anti-psychotic medication influences and affects chemical transmissions to the brain it is undisputed that the purpose of these drugs is to either rapidly or gradually alter, or blunt a patient's thoughts, moods, beliefs, sensations, behavior, motivation, cognition and personality. Rogers v. Okin, supra, 478 F. Supp. at 1366 (App. at p. 69a, 87a, 90a, 98a); Rogers v. Okin, 634 F. 2d at p. (App. at p. 4a, 5a, 17a, 27a); Roe III, supra, at p. 1003-1105, Davis v. Hubbard, supra, at p. 927; Van Putten, Crumpton, Yale, "Drug

Refusal in Schizophrenia and the Wish to Be Crazy," 33 Arch. of Gen. Psychiat., 1443 (December, 1976) (hereinafter "Van Putten and Crumpton"); DiMascio, Giller, Shader, "Behavioral Toxicity of Psychotropic Drugs: III, Effects of Perceptual and Causative Functions; IV Effects on Emotional (Mood) States," Connecticut Medicine (Oct., 1968) (hereinafter "DiMascio-Behavorial Toxicity"); DiMascio, Shader, Harmatz, Behavioral Toxicity of Psychotropic Drugs: V. Effects on Gross Behavior Patterns," Connecticut Medicine, Vol. 33, No. 4 (April, 1969) (hereinafter "DiMascio, Shader, Harmatz"). (PF # 62-69, 71-84, 92-97.) (App. at p. 92-113.)

"The impact of the chemicals on the brain is sufficient to undermine the foundations of personality." Roe III, supra, at p. 1004. (See also admissions by the defendants at PF #92, 94 (12)). (App. at p. 107-109.)

The use of anti-psychotic agents, especially in higher doses, can have a profound effect on the thought processes, clouding or immobilizing patients' minds and causing clouded consciousness. Rogers v. Okin, supra, 478 F. Supp. at p. 1378 (App. at p. 69a, 87a, 90a, 98a); Rogers v. Okin, 634 F. 2d at p. 653, 655, 657, 660 (App. at p. 4a, 5a, 17a, 27a); Davis v. Hubbard, supra, at p. 928; Rennie v. Klein, supra, 476 F. Supp. at 1301; Roe III, supra, at p. 1003-1005; DiMascio, "Behavioral Toxicity," supra. (PF # 71, 75, 92-97.) (App. at p. 96-99, 107-113.)[3]

Anti-psychotics can also impair perception, cognition, speed of response, organization, problem-solving ability, and

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[3]For a discussion of the adverse mental, physical, emotional and social effects of anti-psychotics see Brooks, "The Constitutional Right to Refuse Anti-Psychotic Medication," 8 Bull. Am. Acad. Psychiat. Law 179 (1981); Comment, "Madness and Medicine: The Forcible Administration of Psychotropic Drugs, 487 Wisc. L. Rev. 497, 511-512, 530-539 (1980).

learning ability, all of which seriously interfere with the patient's ability to function adaptively outside, as well as inside, the hospital. Rennie v. Klein, supra, 476 F. Supp. at 1299; Davis v. Hubbard, supra, at p. 928, n. 13. "DiMascio, Behavior Toxicity," supra. (PF # 71-78a, 92-97.) (App. at p. 96-101, 107-113.)

In addition, for some persons, medication contributes to institutionalization by reducing drive, initiative and planning ability, as well as causing persons to be more passive. Prien and Caffey, "Guidelines for Anti-psychotic Drug Use", The Veterans Administration Central Neuropsychiatric Research Laboratory, Research Report No. 95 (May, 1974) (hereinafter "Prien and Caffey"); Prien, "Symposium, Active Treatment of Chronic Schizophrenic," U.S. Government Printing Office (1974) (hereinafter "Prien-Symposium"); "Crane: Two Decades," supra. (PF # 79-82.) (App. at p. 101-104.)

Anti-psychotics also cause up to 40% of patients taking these drugs to experience a dysphoric reaction to the drugs, where patients complain throughout their treatment with anti-psychotics of feeling "drugged", of having "no drive or ambition", of being "drowsy", or "tired", and "slowed-up". Davis v. Hubbard, supra, at p. 928. Van Putten, "Why Do Schizophrenic Patients Refuse to Take Their Drugs," 31 Arch. of Gen. Psychiat. (July, 1974) (hereinafter "Van Putten - Why Do Schizophrenic Patients Refuse"). (PF # 62.) (App. at p. 92.)

Anti-psychotic drugs may also cause adverse reactions similar to some of the symptoms of psychosis. These reactions are called paradoxical reactions. These "paradoxically" induced acute psychotic reactions are marked by confusion, incoherent rambling, disorientation, paranoid ideation, increased agitation and excitement, violent

behavior and visual and auditory hallucinations. Behavioral toxic effects have disastrous consequences, both therapeutically and potentially to the health of the patient. Davis v. Hubbard, supra, at p. 937 n. 29; Roe III, supra, at p. 1004; "DiMascio", supra; "DiMascio, Behavioral Toxicity", supra. (PF #63-69.) (App. at p. 93-95.)

Based on the evidence introduced at trial the District Court in Rogers v. Okin, supra, 478 F. Supp. at 1366, 1369, found that:

> It is clear from the evidence in this case that psychotropic drugs has the potential to affect and change a patient's mood, attitude and capacity to think.

and that these drugs are "powerful enough to immobolize both body and mind." (App. at p. 69a, 87a, 90a, 98a.) The Court of Appeals adopted the District Court's findings as to the potentially harmful effects of anti-psychotic drugs. 634 F. 2d at p. 653, 655, 657, 660. (App. at p. 4a, 5a, 17a, 27a.)

(See also PF #13-109.) (App. at p. 81-116.)[4]

III THE BENEFITS OF ANTI-PSYCHOTIC DRUGS HAVE BEEN EXAGGERATED BY THE DEFENDANTS.

It is recognized that anti-psychotics do not cure patients and that "many patients who would normally be treated with psychotropics can improve without them and that smaller doses than are traditionally given can often be effective" Rennie v. Klein, supra, 476 F. Supp. at 1298. See also Davis v. Hubbard, supra, at 936, 937; In Re KKB, supra, at p.

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[4]In Goedecke v. State Department of Institutions, supra, at p. 124, the Supreme Court of Colorado found that the reason Goedecke refused anti-psychotic treatment was that he had previously been treated with the drug and had experienced some of its short term, adverse side effects, including passing out, falling down, loss of breath, stiff tongue, disoriented thinking and feeling like being "half dead." In Davis v. Hubbard, supra, at p. 928, the court declared that the drowsiness and sedation caused by the drugs "may lead to 'severe distress' as a consequence of the patient's desire to feel 'wide awake' and 'to think more clearly.' See also fn. 6 at p. 56, supra.

113, 138-141.) (App. at p. 106-107, 117, 125-127.)

Even under the best conditions, doctors find it difficult to predict the patients for which drugs will be effective and those in which drugs will not be effective. "Clinicians have encountered great difficulty in scientifically predicting a particular individual's response to a particular drug, and the results frequently appear paradoxical or idiosyncratic." Roe III, supra, at p. 1003, 1004. See also Davis v. Hubbard, supra, at p. 927, 928.

In addition, major drug studies have shown that at most only 50% of schizophrenics derive some benefit from anti-psychotic drugs, (PF # 111-112.) (App. at p. 117.)[5]

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[5]Dr. Albert DiMascio, the Chief Psychopharmacologist of the Department of Mental Health, who was also the National Secretary-Treasurer of the Amicus American College of Neuropsychopharmocology, agreed with this statement at trial. TR. 29-7-9, 37-27, 49.) See also Gardos, Cole "Maintenance Anti-psychotic Therapy: Is the Cure Worse Than the Disease," 133 Amer. J. of Psychiat. 1 (Jan. 1976).

748. (See also PF #88-91, In fact, as Dr. Harry Solomon, the former Commissioner of the Massachusetts Department of Mental Health, has stated, "The distinctive value of the drugs may well be limited in most instances to their capacity to alleviate the distress of acute emotional decompensation." Bochoven and Solomon, "Comparison of Two Year Follow-up Studies, 1947 to 1952 and 1967 to 1972," 132 Amer. J. of Psychiat. (August, 1975) at p. 800. (PF #116.) (App. at p. 118.) In addition, those who do improve do not show anything approaching a recovery from the disease. A considerable percentage relapse despite the continued use of drugs. "Crane, Two Decades," supra, "Prien and Caffey", supra. (PF #118-124.) (App. at p. 120-121.)

As to the quality of the patient's adjustment after he leaves the hospital the results of drug therapy are even less encouraging. The majority of those who live in the community continue to be unproductive

and are often a burden to their families. Many individuals released to foster homes or to other sheltered environments are as dependent and alienated as those confined to an institution. Crane, "Clinical Psychopharmacology in its 20th Year," 181 Science (July, 1973) (hereinafter "Crane-Clinical Psychopharmacology") (PF #125-129.) (App. at p. 121-123.)

As Chief Justice Burger declared in his concurring opinion in O'Conner v. Donaldson, supra, 422 U.S. at 583, 95 S. Ct. at 2498:

> Despite many recent advances in medical knowledge, it remains a stubborn fact that there are many forms of mental illness which are not understood, some are untreatable in the sense that no effective therapy has yet been discovered for them, and the rates of "cure" are generally low.

In addition to the poor prognosis for patients receiving drugs, anti-psychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in a natural course

of their illness. Carpenter, McGlashan, Strauss, "Treatment of Acute Schizophrenia Without Drugs: An Investigation of Some Current Assumptions," 134 Amer. J. Psychiat. (August, 1975) (hereinafter "Carpenter, McGlashan, Struass"). (PF #130.) (App. at p. 123.)

Furthermore, the present-day practice of immediate and massive medication of patients may be causing patients to have greater rigidity of character structures which are less able to cope with life stresses. "Carpenter, McGlashan, Strauss", supra; (PF #132); (App. at p. 123-124); see also Rennie v. Klein, supra, 476 F. Supp. at 1299, Davis v. Hubbard, supra, at p. 928 n. 13.

SUMMARY OF ARGUMENT

I

Although this Court has not addressed the extent to which Constitutionally protected interests of patients are diminished as a result of their civil commitment, in the prison context it has applied a balancing test if fundamental rights are involved. The stronger the individual's interest the greater the state's burden to justify overriding that interest. In this case there are strong Constitutionally protected liberty interests involved because of the intrusiveness and risks of anti-psychotics and their impact on the privacy and personal security of patients when the drugs are forcibly administered.

II

This Court should find that it need not reach the Constitutional issues raised in the case in light of the recent decision of the

Massachusetts Supreme Judicial Court, resolving similar issues on state law grounds.

III

The Court of Appeals was correct in holding that under Massachusetts law commitment to a hospital is not an adjudication of incompetence, and that before a patient may be treated as incompetent to make treatment decisions, a court must specifically adjudicate him incompetent.

IV

Even if Massachusetts law does not apply, since many patients are functionally competent and able to make their own treatment decisions, the Constitution requires that they be adjudicated incompetent by a court before they are deprived of the fundamental right to reject or to consent to their own treatment, absent an emergency. This is particularly important because of the high risk

of erroneous or arbitrary competency determinations, if doctors, rather than courts, were to determine the legal competency of patients to make treatment decisions.

V

Based on the experience of other hospitals and jurisdictions applying a similar standard to the District Court's findings concerning the effects of the TRO, and the Court of Appeals' finding that the defendants exaggerated the difficulties under the order, this Court should find that the Court of Appeals' standard for forced drugging under the police power satisfies the state's interest in preventing or controlling violence.

The standard also does not sacrifice the strong interests of the individual patient. In addition, requiring the state to consider and to rule out less drastic means than antipsychotic drugs to prevent or to control, violence would protect the patients'

interests without extensive judicial scrutiny or unreasonable judicial involvement in the daily administration of the hospital.

VI

Since the Court of Appeals found that the defendants drug practices violated the patients' Constitutional rights and since the Court was unable to find that the doctors' forced medication procedures were Constitutionally sufficient, based on the facts of the case, with which the District Court is particularly familiar, the remand order to the District Court to determine what procedures are Constitutionally due does not violate the principles of federalism.

ARGUMENT

I THIS COURT SHOULD DISMISS THE WRIT OF CERTIORARI OR SHOULD CERTIFY CERTAIN QUESTIONS TO THE MASSACHUSETTS SUPREME JUDICIAL COURT

This Court should dismiss the writ of certiorari as improvidently granted or it

should certify certain questions about the right of committed patients to refuse anti-psychotic medication under Massachusetts law to the Massachusetts Supreme Judicial Court, in light of its recent decision, Roe III, supra, resolving similar issues on state law grounds. The reasons for this request are detailed in Respondents' Motion To Dismiss The Writ Or In The Alternative To Certify Certain Questions to the Supreme Judicial Court of Massachusetts, filed with this Court.

II THE IMPACT OF ANTI-PSYCHOTIC DRUGS IS SO PROFOUND THAT COMMITTED PATIENTS HAVE A SUBSTANTIAL LIBERTY INTEREST IN HAVING THEIR COMMON LAW AND CONSTITUTIONAL RIGHT TO REFUSE SUCH MEDICATION PROTECTED IN THE ABSENCE OF COMPELLING COUNTERVAILING STATE INTERESTS.

A. The Defendants' Argument That Committed Patients Do Not Have A Common Law And Constitutional Right To Refuse Anti-Psychotic Drugs Is Without Merit.

The defendants argue that there is no Constitutional and common law basis for the right of involuntarily committed patients to refuse anti-psychotic drugs. In

effect, the petitioners seek this Court to declare that traditional common law and Constitutional principles are inapplicable to involuntarily hospitalized patients.

Since anti-psychotic drugs have a profound effect on the thought processes and the personality of the patient and a well established potential for causing severe and irreversible adverse side effects, individuals have a profound interest in having the right to decide whether to accept or to refuse these drugs.

The forced administration of anti-psychotic drugs violates three fundamental liberty interests recognized by the Constitution. First, compulsory anti-psychotic drug treatment encroaches on a patient's interest in his "bodily integrity" and "personal dignity." Second, forced drug treatment denies a patient his right to independently make intimate decisions which are important to the patient. Third,

compelled drug treatment invades a patient's interest in their private thoughts, beliefs and feelings. Each of these interests may not be violated or equally affected in every situation nor may they always outweigh the countervailing interests of the State.

Although it is true that the right of patients to refuse treatment is not specifically enumerated in the Constitution, the question for this Court is whether the right to refuse has been protected and recognized by the common law and the Constitution, through the Constitutional Right to Privacy, the First Amendment and the Due Process Clause of the Fourteenth Amendment.

Because of the substantial personal interests involved, a number of courts, based on different Constitutional provisions, have held or have suggested that persons confined in the State's custody have a Constitutional right to refuse psychiatric treatment, see,

e.g., Rogers v. Okin, 634 F. 2d 650 (1st Cir. 1980) (due process) (App. at p. 5a.); Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979), (privacy, 1st Amendment) (App. at p. 87a-92a); Rennie v. Klein, _____ F. 2d _____ (3rd Cir. July 9, 1981) (due process); Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978), 476 F. Supp. 1294 (D. N.J. 1979) (privacy); Scott v. Plante, 532 F. 2d 939 (3rd Cir. 1973) (privacy and First Amendment); Mackey v. Procunier, 477 F. 2d 877 (9th Cir. 1973) (First and Eighth Amendments); Knecht v. Gillman, 488 F. 2d 1136 (8th Cir. 1973) (Eighth Amendment); Winters v. Miller, 446 F. 2d 65 (2nd Cir. 1971), cert. denied, 404 U.S. 985 (1971) (First Amendment-religious grounds); Davis v. Hubbard, 508 F. Supp. 915 (D. Ohio, 1980) (due process); Souder v. McGuire, 423 F. Supp. 830 (M.D. Pa. 1976) (privacy, Eighth Amendment); Bell v. Wayne County General Hospital, 384 F. Supp. 1085, 1100 (E.D. Mich.

1974) (three-judge court) (privacy and due process); In the Matter of Guardianship of Richard Roe, III, 1981 Mass. Adv. Sh. 981 (Mass. 1981), (privacy); In Re K.K.B., 609 P. 2d 747 (Okla Sup. Ct. 1980) (privacy); In Re Boyd, 403 A.2d 744 (D.C. Ct. App. 1979) (privacy); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E. 2d 417, 424, (Mass. 1977) (privacy); Price v. Shepard, 307 Minn. 250, 239 N.W. 2d 905 (Minn. 1976) (privacy); Kaimowitz v. Michigan Department of Public Health, No. 73, 19434 AW, 42 U.S.L.W. 2063, 2 Prison Law Rptr. 433 (Mich. Cir. Ct., Wayne City Mich., July 10, 1973) (privacy, First Amendment).

A number of state courts relying on state law grounds have also held that there is a right of hospitalized patients to refuse intrusive treatments. See Mitchell v. Robinson, 334 S.W. 2d 11 (Mo. (1960), In re Yettes, 62 Pa. Dist. and Cty. Rpts. 619

(1972); Goedecke v. State of Colorado Department of Institutions, supra, New York Health and Hospital Corp. v. Stein, 335 N.Y.S. 2d 461, 70 Misc. 2d 944 (Sup. Ct. N.Y. 1973); In re Quackenbush, 150 N.J. Super. 282, 383 A. 2d 785 (1978).

In order for this Court to determine if involuntarily committed patients' interests in refusing anti-psychotic drugs deserve Constitutional protection it must begin with an examination of "the teachings of history [and] ... recognition of the basic values that underlie our society." Moore v. City of East Cleveland, 431 U.S. 494, 503, fn. 10, 503-04, fn. 11, 12; 97 S. Ct. 1932, 1937-1938, n. 10-12, 52 L. Ed. 2d 531 (1977), citing to Griswold v. Connecticut, 381 U.S. 479, 501, 85 S. Ct. 1648, 1651, 14 L. Ed. 2d 510 (1965) (Harlan, J. concurring); Ingraham

v. Wright, 430 U.S. 651, 672-74, 97 S. Ct. 1401, 51 L. Ed. 2d 711 (1977); Roe v. Wade, 410 U.S. 113, 152, 93 S. Ct. 705, 35 L. Ed. 2d 147 (1973).

In the history of the common law, there is no right that is older or more cherished than the right of a person to be free of unwarranted intrustions into his mental and bodily processes. See e.g., Ingraham v. Wright, supra, 430 U.S. at 673, 97 S. Ct. at 1413; Breithaupt v. Abrams, 352 U.S. 432, 439, 77 S. Ct. 408, 412, 1 L. Ed. 2d 448 (1957). This common law principle, derived from English law, has been adopted by American courts as a fundamental principle of law. (See Davis v. Hubbard, supra, at p. 930-931 for a thorough discussion of the derivation of the right from English law.) See also Canterbury v. Spence, 464 F. 2d 772, 780 (D.C. Cir. 1972); cert. denied, 409 U.S. 1064, 93 S. Ct. 560, 34 L. Ed. 518 (1972). In English and American jurisprudence individuals have the

right to choose between accepting or rejecting medical treatment recommended to them by a physician. Moos v. U.S., 225 F. 2d 705, 706 (8th Cir. 1975); "Developments in the Law--Civil Commitment of the Mentally Ill" 87 Harv. L. Rev., 1190, 1194, fn. 10 (April 1974) (hereinafter "Developments") See also Dunham v. Wright, 423 F. 2d 940, 941 (3rd Cir. 1970); Scholendorff v. Society of New York Hospitals, 211 N.Y. 125, 105 N.E. 932 (1914), (Cardozo, J.); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (Minn. 1905); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (Ill. 1906).

This common law right to decide whether or not to accept treatment is related to the doctrine of informed consent which recognizes a person's interest in making his own decisions about his body. See Superintendent of Belchertown v. Saikewicz, supra, 370 N.E. 2d at 424. See also Roe III, supra.

This concept is embodied in Harper and James' treatise on tort law:

> "The very foundation of the doctrine [of informed consent] is every man's right to forego treatment or even cure if it entails what for him are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortiion falls short of what the law regards as incompetency. Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish."

2 F. Harper and F. James, Jr., The Law of Torts 61 (1968 Supp); see also Cobbs v. Grant, 8 Cal. 3rd 229, 243, 502 P. 2d 1, 10, 104 Cal. Rptr. 505, 514 (Cal. 1972).

Our own Constitutional history contains many references to the importance of the inviolability of the person. As early as 1886 the Supreme Court declared that an unlawful invasion of the sanctity of the individual constitutes a violation of the Fourth and Fifth Amendments. Boyd v. United States, 116 U.S. 616, 630, 6 S. Ct. 524, 29 L.Ed. 746 (1886). See also

Union Pacific Co. v. Botsford, 141 U.S. 250, 251, 11 S. Ct. 1000, 1001, 35 LEd 734 (1891). The interest in protecting the inviolability of a person also forms the basis of the due process clauses of the Fifth and Fourteenth Amendment. See Roe v. Wade, supra, 410 U.S. at 153, 93 S. Ct. at p. 726, 727; Ingraham v. Wright, supra.

B. The Right To Refuse Anti-Psychotic Drugs May Be Derived From The Due Process Clause Of The Fourteenth Amendment.

The framers of the Constitution believed that "the full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in the Constitution." Moore v. City of East Cleveland, supra, 431 U.S. at 502, 97 S. Ct. at p. 1937 quoting Poe v. Ullman, 367 U.S. 497, 542-543, 81 S. Ct. 1752, 1776, 1777, 6 LEd 2d 989 (1961) (Harlan, J. dissenting).

This Court "has not attempted to define

with exactness the liberty... guaranteed [by the Fourteenth Amendment]" ...

> "Without doubt it denotes not merely freedom from bodily restraint but also the right of the individual... generally to enjoy those privileges long recognized... as essential to the orderly pursuit of happiness by free men." (citations omitted)

Board of Regents v. Roth, 408 U.S. 564, 572, 92 S. Ct. 2701, 2706, 33 L. Ed. 2d 548 (1972); quoting Meyer v. Nebraska, 262 U.S. 390, 399, 43 S. Ct. 625, 67 L.Ed. 1042 (1923). "In a Constitution for a free people, there can be no doubt that the meaning of 'liberty' must be broad indeed." Board of Regents v. Roth, supra, 408 U.S. at p. 572, 92 S. Ct. at p. 2707.

Among the historic liberties [protected by the Due Process Clause] was a right to be free from... unjustified intrusions on personal security." Ingraham v. Wright, supra, 430 U.S. at 673, 97 S. Ct. at 1413. The right of hospitalized patients to refuse powerful, dangerous, mind-altering drugs is

among those historic liberties protected by the Due Process Clause.

The First Circuit, in the case at bar, found the "[i]ntuitively obvious proposition" that patients have a "Constitutionally protected interest in being left free by the state to decide for himself whether to submit to this serious and potentially harmful medical treatment that is represented by the administration of anti-psychotic drugs" in the Due Process Clause of the Fourteenth Amendment, "as part of the penumbral right to privacy, bodily integrity, or personal security." 634 F. 2d at p. 653 (App. at p. 4a.) See also Parham v. J.R., 442 U.S. 584, 626, 99 S. Ct. 2493, 2516, 61 L. Ed. 2d 101 (1979) (Brennan, J., dissenting on other grounds); Davis v. Hubbard, supra, at p. 929-933.

C. The Right To Refuse Anti-Psychotic Drugs May Be Derived From The Constitutional Right To Privacy.

The right to refuse anti-psychotic drugs

may also be derived from the penumbras of specific amendments to the United States Constitution. See Griswold v. Connecticut, supra.

The Supreme Judicial Court of Massachusetts has held that the Constitutional right of privacy extends to institutionalized patient's right to refuse chemotherapy treatment

> ...as "an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice."
>
> Superintendent of Belchertown v. Saikewicz, supra, 370 N.E. 2d at 424, 426.
>
> "The Constitution does not explicitly mention any right of privacy. In a line of decisions, however, going back... as far as Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251, 11 S. Ct. 1000, 1001, 35 L. Ed. 734 (1891), the [United States Supreme] Court has recognized that a right of personal privacy, or a guarantee of certain zones of privacy,... does exist under the Constitution."

Roe v. Wade, supra, 410 U.S. at 152, 93 S. Ct. at 726.

"While [t]he outer limits of the right to privacy have not been determined by this Court," Carey v. Population Services International, supra, 431 U.S. 678, 684, 97 S. Ct. 2010, 2016, 52 L. Ed. 2d 675 (1977), the Court has sought to insure that the area encompassed by the right of privacy, like the "liberty" protected by the Due Process Clause,

> is not a series of isolated points pricked out in terms of the [Bill of Rights, but] a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints... and which also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgement.

Poe v. Ullman, supra, 367 U.S. at 542-543, 81 S. Ct. at 1776-1777 (Harlan, J., dissenting) (citations omitted). In order to deserve Constitutional protection a patients' decisions must meet two criteria. First, it

must be "personal decisions." They must directly involve one's self or one's family. Second, they must be "important decisions." Whalen v. Roe, 429 U.S. 589, 599, 600, 97 S. Ct. 869, 876, 51 L. Ed. 2d 64 (1977). Carey v. Populations Services International, supra, 431 U.S. at 684, 97 S. Ct. 2015. They must substantially affect one's development or one's life. The right to decide whether to obtain or to reject anti-psychotic drugs meets both criteria.

Commenting on Justice Brandeis' seminal decision, Olmstead v. Unites States, supra, 277 U.S. 438, 48 S. Ct. 564, 72 L.Ed. 2d 944 (1928) which declared that all persons have the "right to be let alone," Chief Justice Burger stated in his concurring opinion in Application of Pres. and Dir. of Georgetown College, 331 F. 2d 1000, 1017 (D.C. Cir. 1964),

> Nothing in this utterance suggests that Justice Brandeis thought an individual possessed rights only to 'sensible'

> beliefs, 'valid' thoughts, 'reasonable' emotions or 'well-founded' sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk.

See also Rogers v. Okin, supra, 478 F. Supp. at p. 1367 (App. at p. 90a-92a); Roe III, supra, at p. 1017, fn 20.

D. The Right To Refuse Anti-Psychotic Drugs May Be Derived From The First Amendment.

In addition to offending a patient's interest in physical dignity, autonomy and security and his ability to make independent, personal decisions about his body and mind, the compulsory administration of anti-psychotic drugs intrudes upon a patient's private thoughts, feelings and personality, thereby requiring the protection of the First Amendment. Rogers v. Okin, supra, 478 F. Supp. at p. 1366, 1367 (App. at p. 69a, 87a, 90a-92a, 98a.) The First Circuit's opinion

affirmed these District Court's findings. (App. at p. 4a, 5a, 17a, 27a.)[6]

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[6]In Roe III, supra, at p. 1003, 1004, the Supreme Judicial Court of Massachusetts stated that it could "identify few legitimate medical procedures which are more intrusive than the forcible injection of anti-psychotic medication." The Court held that it is "virtually undisputed they are mind altering", "are powerful enough to immobilize both body and mind" and "the impact of the chemicals upon the brain is sufficient to undermine the foundation of personality." The court in Davis v. Hubbard, supra, at p. 928, 937 held that anti-psychotic drugs "deaden the patient's ability to think...", cause depression and may cause psychiatric deterioration by exacerbating the symptoms of the disorder for which they were given. In In re Cleo Lundquist, No. 140154 (April 30, 1976), cited in Matter of B., 156 N.J. Super. 231, 383 A. 2d 760, 763 (Sup. Ct., N.J. 1977), the Court found that one injection of Prolixin Decanoate "may produce changes in the patient's mental processes lasting from four to eight weeks and [t]hat once injected into the body there is no known drug that can be used to counteract the effects of Prolixin Decanoate". The Court in In re Boyd, supra, 403 A. 2d 744, 752 (D.C. Ct. App. 1979) found that one of the unpleasant side effects of anti-psychotic drugs is "slowing of the thought processes". In Goedecke v. State of Colorado Department of Institutions, supra, at p. 123-125, the Supreme Court of Colorado held that Colorado law protects an involuntarily detained patient from being forced to undergo treatment with drugs having serious deleterious side effects in non-emergency situations, and found that Prolixin, "aside from its physical side effects" and "behavior modifying capacity,"... "causes severe depression (often accompanied by suicidal feelings) in 25-30 percent of the persons treated with it," and "causes severe side effects in half of the patients treated with it."

If the evidence in the case at bar had demonstrated that the personality and mind altering capacity of these drugs only had a "therapeutic" effect on patients and did not have the capacity to immobilize the mind or to cause any adverse impact on the intellectual and emotional processes, the question presented would be whether the state has the right to intentionally alter a patient's thought and emotional processes when the patient is legally competent and may in fact be able to rationally weigh the risks and benefits of anti-psychotic drugs.

Since the First Amendment protects the communication of ideas, Abrams v. United States, 250 U.S. 616, 630, 40 S. Ct. 17, 63 L. Ed. 1173 (1919); Brandenberg v. Ohio, 395 U.S. 444, 89 S. Ct. 1827, 23 L. Ed. 2d 430 (1969), and thought is a necessary condition of free speech, the First Amendment protects the privacy of the thoughts and feelings of patients who are competent and who are able

to weigh the risks and benefits of anti-psychotic medication. To hold otherwise and to permit state doctors to determine whether or not to alter the thoughts and personality of legally and functionally competent patients would seriously threaten the underlying values of the First Amendment. See, e.g., Griswold v. Connecticut, supra, 381 U.S. at p. 482; United States v. Reidel, 402 U.S. 351, 359-360, 91 S. Ct. 1410, 1414, (1971) (Harlan, J., concurring). Mind control is repugnant to the underlying values of our political system. Stanley v. Georgia, 394 U.S. 557, 565, 566, 86 S. Ct. 1826, 16 L. Ed. 2d 908 (1966) and Paris Adult Theatre I v. Slaton, 413 U.S. 49, 67, 68, 93 S. Ct. 2628, 2640, 2641, 37 L. Ed. 2d 446 (1973).

Even if it is assumed that the First Amendment does not protect totally disordered thought, mere hospitalization is not a rational or reasonable point at which to

distinguish between that thought which is unprotected by the Constitution and that which deserves protection. A specific finding of incompetence would be the only legitimate point of demarcation. In Massachusetts this can only be lawfully determined by a court. Roe III, supra.

However, in this case there is even a more fundamental First Amendment issue since anti-psychotic medication has the capacity to not only 'therapeutically' alter thought and emotional processes, but to immobilize both body and mind and to cause adverse alterations of mood and personality. This case concerns the very foundation of the First Amendment; the generation of thoughts and feelings which are essential before communication can take place. Since the act of speaking and communication requires thought processes, it is these thoughts and feelings and mental acts which must be protected by the First Amendment. If the First Amendment

does not protect the generation of thoughts and feelings of persons who are both legally and functionally competent, the First Amendment is meaningless. Kaimowitz v. Michigan Department of Public Health, supra.

Furthermore, the right to refuse anti-psychotic drugs in non-emergencies is necessary to protect the plaintiffs from medication used by the defendants and their staff to control and to subdue what the staff believed was "bizarre" or "morally offensive behavior" and to chill First Amendment rights.[7]

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[7]This is highlighted by the case of the plaintiff Elizabeth Bybel. In December 1973 and January 1974, Elizabeth Bybel was telling patients they had the right to refuse their medication and was telling the patients that the staff was "incompetent". Layne Erban, the nursing supervisor of Austin Unit stated that Bybel was a "ringleader" and that such behavior would not be tolerated and that one of the methods to be used to alter the behavior was to increase her medication. She was then oversedated. (PF #97L, 97(h)(1), 285-287.) (App. at p. 112-113, 185.)

The District Court found that during January and February 1974 "Bybel received large dosages of phenothiazines" and that there was evidence "she suffered from slowed thinking and slurred speech following that medication." (App. at p. 74.)

E. The Right To Refuse Anti-Psychotic Drugs May Be Derived From Liberty Interests Created By State Law.

Liberty interests may be created and defined by state laws. Once a liberty interest is found to arise under state law, unjustified or arbitrary deprivations of the right violates a citizen's rights under the due process clause of the Fourteenth Amendment, Wolff v. McDonnell, 418 U.S. 539, 94 S. Ct. 2963, 41 L. Ed. 2d 935 (1974) (good time credits); Morrissey v. Brewer, 408 U.S. 593, 92 S. Ct. 2694, 33 L. Ed. 2d 570 (1972) (revocation of parole).

In Roe III, the Supreme Judicial Court, based on state common law grounds, reaffirmed its prior holding that all competent and incompetent individuals in Massachusetts have a fundamental right to refuse treatment, "absent an overwhelming state interest." Roe, supra, at 1001. This liberty interest, arising under state law, requires Constitutional protection.

III THE COMMONWEALTH'S INTEREST IN FORCIBLY MEDICATING PATIENTS MUST BE SUFFICIENT TO OVERCOME THE PATIENTS' RIGHT TO LIBERTY AND CONSTITUTIONALLY PROTECTED MENTAL AND BODILY PRIVACY.

A. Careful Balancing Of The State's Interests And Of Patient Constitutionally Protected Interests Is Required.

Although this Court has not addressed the extent to which Constitutionally protected interests of patients are diminished as a result of their civil commitment, the Court has declared that even convicted persons "do not forfeit all Constitutional protections by reason of their conviction and confinement in prison." Bell v. Wolfish, 441, U.S. 119, 129, 99 S. Ct. 1861, L. Ed. 2d (1979). This Court has recognized that there must be a "mutual accommodation between institutional needs and objectives and the provisions of the Constitution that are of general application." Wolff v. McDonnell, supra, 418 U.S. at p. 556. Where fundamental rights are involved rather than mere conditions of confinement, this Court has

applied a balancing test. Bell v. Wolfish, supra. The stronger the individual interest affected the greater the state's burden to justify overriding that interest.

Our legal system has long recognized that few decisions in an individual's life are as private, intimate and fundamental as the decision to consent to or to refuse medical treatment that interferes with the person's bodily and mental privacy. Therefore, if the state is to justify the forcible medication of involuntary mental patients, with anti-psychotic drugs, amounting to an unconsented to instrusion into their mind, body and personality, the state must prove the interest in coercing anti-psychotic drugs is compelling enough to outweigh the individual's fundamental right to refuse such drugs. See Jacobson v. Massachusetts, 197 U.S. 11 (1905); Roe v. Wade, supra, 400 U.S. at 155, 93 S. Ct. at 728; see also Rennie v. Klein, F. 2d, supra, slip op. at p. 14, fn. 8.

1. Forced Anti-Psychotic Medication Constitutes a Major Change In The Conditions Of Confinement And Therefore Requires Constitutional Protection.

The defendants argue that a patient's involuntary submission to any forced anti-psychotic drugs the hospital prescribes for him is a necessary incident of his involuntary commitment; this is just one of the rights which he loses upon his confinement to the hospital. (Defendants Brief at p. 19-20.)

However, intrusive forms of treatment, such as anti-psychotic drugs, constitute an additional and greater loss of liberty than civil commitment, which is not justified or a necessary condition of commitment. "Compulsory medication of a non-consenting patient with its serious concomitant risks must be deemed a 'major change in the conditions of confinement.' Rennie v. Klein, F. 2d, supra, slip. op. at p. 14. See also Wolff v. McDonnell, supra, 418 U.S. at 571-72

n. 19, 94 S. Ct. at 2982. In Vitek v. Jones, supra, 445 U.S. 480, 100 S. Ct. 1254, 63 L. Ed. 2d 552 (1980) this Court held that since a prisoner, who was to be transferred to a mental hospital, was to be subjected to a mandatory behavior modification program, it constituted a major change in the conditions of confinement, requiring substantial due process protections.

Forced drug treatment implicates the "right to be free from and to obtain judicial relief for, unjustified intrusions on personal security." Ingraham v. Wright, supra. See also Runnels v. Rosedale, 499 F. 2d 733, 735 (9th Cir. 1974) and Commission of Correction v. Myer, 1979 Mass. Adv. Sh. 2534 (1979).

IV ABSENT AN EMERGENCY, THE STATE DOES NOT HAVE A SUFFICIENT STATE INTEREST TO FORCIBLY DRUG INVOLUNTARILY COMMITTED PATIENTS UNDER THE PARENS PATRIAE POWER UNLESS THE PATIENT IS SPECIFICALLY ADJUDICATED INCOMPETENT TO MAKE HIS OWN TREATMENT DECISIONS.

The defendants present three arguments

in support of their claim that the State's paren patriae power gives them the authority to forcibly drug patients, asserting that the State's interests outweigh the patient's right to refuse anti-psychotic drugs.[8] First, the defendants argue that as a matter of Massachusetts law involuntary committed patients, as a result of being committed by a court, are judicially determined to be unable to make treatment decisions. The defendants assert that under Massachusetts law civil commitment and its concomitant finding of "mental illness" constitute a sufficient determination of incapacity to justify forcing anti-psychotic drugs over the objections of the patients. The defendants also

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[8]In its brief the defendants recognize that the only valid state justifications for forced drug treatment are the state's parens patraie and police power. (Defendant's Brief at p. 57-59). These state interests will be addressed separately in the plaintiffs' brief.

claim that this is true whether the patient is committed pursuant to the state's police or parens patraie power. Secondly, the defendants argue that a result of the issuance of a court involuntary commitment order is the authority and the duty to involuntarily treat. Finally, they assert that state law and the Constitution provide them the administrative discretion to forcibly drug patients since the "treatment is directly related to the purpose for which mental patients in Massachusetts are committed." (Defendants' brief at p. 12.) As will be shown, each of these three rationales for exercising parens patriae forced drugging is unsupportable as a matter of fact, as well as a matter of State and Constitutional law.

A. Interpreting Massachusetts Law, The Supreme Judicial Court Has Reaffirmed That Involuntary Committment To A Hospital In Massachusetts Is Not An Adjudication Of Incompetency Nor Does Commitment Mean That A Patient Is Incompetent To Make Treatment Decisions.

The District Court and the Court of

Appeals found that under Massachusetts statutory law and judicial precedent a committed patient is not deemed to be incapable of making treatment decisions. The District Court and Court of Appeals also held that under Massachusetts law the state did not have a duty to provide anti-psychotic drugs forcibly under its parens patriae power, and that before such treatment could be forced an involuntary patient had to be specifically adjudicated incompetent by a court. (App. at p. 16a-26a, 73a-75a).

In Roe III, the Supreme Judicial Court explicitly held that the District Court and Court of Appeals' decisions were correct in their interpretation of the Massachusetts commitment statute. The Court declared that under Massachusetts law there is a "profound" distinction between commitment and the finding of mental illness, and a determination of incompetency to make treatment decisions. The Court stated that under

Massachusetts law, even if a person is found to be generally incompetent to handle his or her affairs, without an independent finding of incompetency to make anti-psychotic treatment decisions, a ward would still legally retain the capacity to make the "treatment decision of this magnitude."[9] Roe III, supra, at p. 1009. The Supreme Judicial Court in Roe III, supra, at p. 1008, 1009 merely reaffirmed Massachusetts law that commitment to a hospital and a judicial finding of mental illness is not an adjudication or finding that the patient is unable to make his own treatment decisions, or that a patient's thoughts are

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[9]The American Psychiatric Association at fn. 6, p. 8 of the brief recognizes this when it distinguishes Massachusetts law from states in which a parens patraie commitment includes a finding of incapacity. For those states the defendants are correct that patients can no longer personally retain the right to refuse since their commitment is an adjudication of incompetency to make treatment decisions.

so disordered as to be irrational.[10]

Therefore, this Court should hold that Roe III,

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[10]Prior decisions to Roe III, have held that a person diagnosed as mentally ill and committed to a mental institution is considered competent and able to rationally contract, transfer or dispose property and care and manage his property, Mitchell v. Mitchell, 312 Mass. 165, 168, 43 N.E. 2d 779 (1949); Leggate v. Clark, 111 Mass. 308, 310 (1873); Op. Atty. Gen. September 13, 1963, p. 116; as well as to vote, Boyd v. Board of Registrars of Voters of Belchertown, 368 Mass. 681, 334 N.E. 2d 629, 632, 633 (1975), to testify in court, Commonwealth v. Sires, 370 Mass. 541, 350 N.E. 2d 460 (1976); and to be competent to stand trial for alleged criminal conduct; Commonwealth v. Hill, Mass., 375 N.E. 2d 1168 (1978), unless the patient is found, in addition to being mentally ill, to have an "inability to think or act for himself as to matters concerning his personal health, safety and general welfare; or to make informed decisions as to his property and financial interests," Fazio v. Fazio, 376 N.E. 2d 956, 957 (1978) (emphasis added).

In addition, as the Court of Appeals noted, as part of the statutory recognition of patients' rights the legislature included a provision in the mental health statute guaranteeing patients the right to be treated as competent to manage their affairs unless specifically adjudicated incompetent by a court. M.G.L. c. 123 §25. (App. at p. 193a-194a.) Pursuant to M.G.L. c. 123 §2 and consistent with M.G.L. c. 123 §25, the Department of Mental Health promulgated a regulation consistent with M.G.L. c 123 §25, declaring that involuntarily committed patients, unless adjudicated incompetent, should be treated as competent. D.M.H. Reg. § 221.02. (App. at p. 23.)

specifically rejects the defendants' argument that under state law the Commonwealth assumes the "decision making role" for committed patients merely because they are mentally ill." (See Defendants' brief at p. 13).

B. In Interpreting Massachusetts Law, The Supreme Judicial Court Has Held That Commitment Does Not Justify Forced Medication Under The State's Parens Patriae Power.

The Court in Roe III, supra, at p. 1009, stated that under Massachusetts law the

> "commitment decision itself is an inadequate predicate to the forcible administration of drugs to an individual where the purported justification for that action is the State's parens patriae' power."

Since the Supreme Judicial Court, interpreting state law, has held the State

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Roe III and prior Massachusetts cases, the state mental health code and DMH regulations indicate that Massachusetts law regards mentally ill patients as legally competent to make treatment decisions even though committed to a hospital, until the appropriate Court has determined otherwise.

does not have the authority to forcibly drug patients under the parens patriae power, whether based on a 'duty to treat' or an 'administrative discretion' theory, this Court need not address whether Massachusetts may Constitutionally force anti-psychotic drugs on its competent citizens.

C. Even If State Law Permits The State To Involuntarily Medicate Patients Under The Parens Patriae Power, Such a Practice Would Violate Patients' Constitutional Rights Unless The Patient Is Specifically Adjudicated Incompetent.

1. Many Involuntarily Committed Patients Are In Fact Competent To Refuse Treatment And To Provide Informed Consent.

Even though the plaintiffs may have some mental limitations, Massachusetts law, the District Court's factual findings, and the clear weight of the evidence reject the defendants' contention that all of the plaintiffs' mental processes are actually disordered and as a result they are really unable to give consent to treatment. (See PF

#98-109, 226-228.) (App. at p. 30, 36-37, 113-116, 163-164.)

The District Court found that:

> The weight of evidence persuades this court that, although committed mental patients do suffer at least some impairment of their relationship to reality, most are able to appreciate the benefits, risks and discomfort that may reasonably be expected from receiving psychotropic medication. This is particularly true for patients who have experienced such medication and, therefore, have some basis for assessing comparative advantages and disadvantages. 478 F. Supp. at p. 1361. (App. at p. 74a.)[11]

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[11] For evidentiary support of this finding see PF #98-169, 226-228. (App. at p. 165-169, 250-251.) The District Court found support for its findings in the D.M.H. Civil Rights form "posted on walls of the Austin and May wards stating that patients have the right 'to refuse treatment at any point'," "be told in detail what is wrong with you, what alternative treatments are available and to choose from these alternatives." (App. at p. 67a-68a, 75a, fn. 13.) (See also App. at p. 36-38.) Furthermore the Department of Mental Health itself treated committed patients as if they were competent. In addition to the Civil Rights form described above, the Admission Packet provided to all patients upon their admission states that "no medical or surgical treatments including electroconvulsive treatment are given without the consent of the patient." (App. at p. 22a, 30a, 68a.)

The Court of Appeals affirmed these findings. 634 F. 2d at p. 659. (App. at p. 22a.)

Psychiatric literature supports the District Court and Court of Appeals' finding that many forms of mental illness have an impact on a specific part of a person's functioning, leaving other parts of decision making capacity and reasoning largely intact. See Plotkin, "Limiting the Therapeutic Orgy; Mental Patients' Right to Refuse," 72 N.W. U. L. Rev. 461, 489, fn. 167 (1977); "Developments" at p. 1214, n. 80; and American Bar Foundation, The Mentally Disabled and the Law (252-255) (S. Brakel and R. Rock eds. rev. ed. 1971). This

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The defendants conceded that not all committed patients are incapable of making their own treatment decisions. (App. at p. 22a.) In addition, it should be noted that the defendants represented to the trial court that they were not seeking to forcibly medicate patients competent to decide for themselves. Rogers v. Okin, supra, at 478 F. Supp. 1361 citing Defendants' Trial Brief, p. 27. (App. at p. 73a.)

finding by the District Court, affirmed by the Court of Appeals, is consistent with the weight of authority in American law that the mere presence of mental illness or incapacity in one area does not constitute a general incapacity in all areas. [12]

If the defendants were correct in asserting that committed patients are functionally incompetent to make rational treatment decisions, but can make all other decisions about their lives, one would not expect the Massachusets law or the Department of Mental Health (DMH) to provide patients with the right to refuse any form of medical or surgical treatment. But this is not the

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[12]Courts throughout the country in numerous areas of the law have held that a specific incapacity to undertake a relevant function rather than the mere presence of mental illness is required to justify the state exercising its parens patraie power. See "Developments" at p. 1214, 1215, fn. 81, 82.

case.[13] (See Admission Packet, App. at p. 22a, 30, 68a.)

The defendants may argue that the plaintiffs are functionally competent to make medical and surgical decisions, but are unable to make rational psychiatric treatment decisions. But the state legislature specifically permits patients to refuse electroshock and psychosurgery, M.G.L. c.123 §23 (App. at p. 191a-193a.) Secondly, the DMH's Patient's Rights Form permits patients to refuse all psychiatric treatments. (App. at p. 67a-68a, 75a, fn.

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[13]Under Massachusetts law a court adjudication of incompetency is necessary before non-emergency surgery on a patient committed to a mental health facility may be performed. See opinion of Attorney General Edward Brooke to the Commissioner of the Department of Mental Health, Dr. Harry Solomon. Op. Atty. Gen. Feb. 9, 1966, p. 247. See also Lane v. Candura, 1978 Mass. App. Ct. Adv. Sh. 588, 376 N.E. 2d 1232 (1978) affirming the right of a person not adjudicated incompetent to refuse life-saving medical treatment; Baird v. Attorney General, 371 Mass. 741, 360 N.E. 2d 288, 296 (1977) involving questions of a minor's consent to an abortion, and Reddington v. Clayman, 334 Mass. 244, 135 N.E. 2d 920 (1956).

13, 36-38.) Thirdly, the Admission Packet, provided patients upon their admission, requires their consent for electroconvulsive shock treatments.[14] (App. at p. 22a, 30, 68a.)

In addition, a number of courts have found that the reasons many patients refuse anti-psychotic drugs are both rational and reasonable. Rennie v. Klein, supra, 476 F. Supp. at 1299; Goedecke v. State of Colorado Department of Institutions, supra at p. 124, 125. In re KKB, supra at p. 748.[15]

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[14]The defendants may attempt to distinguish the right to involuntarily medicate patients but not to use electroshock without consent on the differences between these treatments, in terms of their intrusiveness and risks, but based on the Massachusetts Supreme Judicial Court's decision in Roe III, supra, it would be unsupportable. The Court held that anti-psychotic drugs should be treated in the same manner as electro-convulsive therapy.

[15]For example, the courts and medical literature have found that patients find the side effects caused by anti-psychotics to be uncomfortable or unbearable and the suffering from even mild extra-pyramidal side effects (dystonia, akathesia, akinesia and tardive dyskinesia) often leads to outright drug reluctance or

2. The Commitment Decision is Not Legally Synonomous With An Adjudication Of Incompetence.

The defendants argue that as a matter of Constitutional law a patient may be

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self-prescribed reduction of dosage. Rennie v. Klein, supra, 476 F. Supp at 1306; Davis v. Hubbard, supra at p. 936; "Van Putten, Why Do Scizophrenic Patients Refuse," supra; Van Putten and May, "Subjective Response as a Predictor of Outcome in Pharmacotherapy: The Consumer Has a Point," 35 Arch. of Gen. Psyciat. (hereinafter "Van Putten and May"). (PF #98, 99, 100) (App. at p. 113-114.)

However, these side effects and the patients' reaction to them are often ignored or disregarded by physicians. Rennie v. Klein , supra, 476 F. Supp at p. 1299-1303; Davis v. Hubbard, supra, at p. 936 n. 28; (See also PF #223-225.) (App. at p. 162-163.)

Patients also react negatively to the sedative effects of the drugs. Patients refuse, because they experience dysphoric responses to the neuroloeptic drugs; feelings of psychological distress and discomfort; feeling "drugged," having "no drive or ambition," being "drowsy," or "slowed up." Goedecke v. State Dept. Institutions, supra at p. 124; Davis v. Hubbard, supra at p. 928. "Van Putten, Why Do Schizophrenic Patients Refuse," supra; "Van Putten and May," supra. (PF #101-103.) (App at p. 115.)

Often patients refuse because they recognize the long-term consequences of heavy and prolonged use of anti-psychotic drugs, in producing such disorders as tardive dyskinesia, which is generally thought to be irreversible. (PF #108, 109) (App. at p. 116.) (See also PF 104, 105, 107.) (App. at p. 115, 116.)

forcibly drugged under the State's parens patriae power once he is committed and found to be mentally ill even if commitment under Massachusetts law does not specifically constitute a finding of such incapacity.

However, in order for the state to Constitutionally invoke its interest in protecting those unable to protect themselves:

> "the individual himself must be incapable of making a competent decision concerning treatment on his own." Otherwise the very justification for the state's proported exercise of its parens patriae power - its citizens' inability to care for himself, see Addington v. Texas, supra, 441 U.S. at 426, would be missing." (App. at p. 17a.)

The exercise of state authority must at least be reasonably related to the state purposes to be served. Jackson v. Indiana, 406 U.S. 715, 738, 92 S. Ct. 1845, 1858, 32 L. Ed. 2d 435 (1972). As the Court of Appeals pointed out, neither court commitment nor the judicial finding of mental illness in Massachusetts is reasonably related to incompetency to make treatment decisions and,

therefore, is not a Constitutionally sufficient predicate to state action based on its parens patriae power. (App. at p. 16a-23a.)

> [T]he sine quo non for the state's use of its parens patraie power as justification for the forceful administration of mind-affecting drugs is a determination that the individual to whom the drugs are to be administered lacks the capacity to decide for himself whether he should take the drugs. (App. at p. 17a-18a.)

See also "Developments" at p. 1212-1216; Rennie v. Klein, F. 2d, supra, (Garth concurring), slip op. at p. 43-46.

3. To Forcibly Medicate Based On The Conclusive Presumption That Patients Are Incompetent Would Violate Due Process.

To permit forced treatment of patients under the State's parens patriae power, based on the conclusive presumption that committed patients are unable to make rational medication decisions, when many are in fact competent, would deny the plaintiffs their right to due process of law. Cleveland

Board of Education v. Lafleur, 414 U.S. 632, 643-648, 94 S. Ct. 791, 798-799, 39 L. Ed. 2d 52 (1972); Goldberg v. Kelly, 397 U.S. 254, 90 S.Ct. 1011, 25 L. Ed. 2d 287 (1970); see also Vitek v. Jones, supra, 445 U.S. at 491-494 (1980); McAuliffe v. Carlson, 377 F. Supp. 896, 905 (D. Conn. 1974); Bell v. Wayne County General Hospital, supra, at p. 1102.[16]

4. Patients Committed Under The Police Power Are Not Committed Because of The Inability To Care For Themselves, And Therefore They Cannot Be Forcibly Medicated Because They Are Incapable Of Caring For Themselves.

The Court of Appeals indicates that a

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[16]Many courts have also held, as did the lower courts in this case, that a committed patient is presumed to be competent and a court cannot override the treatment decision of the patient unless he or she has been specifically adjudicated incompetent. Rennie v. Klein, supra, slip. op. at 19 and n. 12; Winters v. Miller, supra at 68, 69; In re Boyd, supra, at p. 747 n. 5; New York Health Corporations v. Stein, supra, at p. 465; In re K.K.B., supra at p. 749; Goedecke v. State of Colorado Department of Institutions, supra, Davis v. Hubbard, supra, at p. 935.

practical problem is created if the State forcibly medicates a patient using its parens patriae power, relying on the assumption that committed patients are judicially determined to be incapacitated. In interpreting Massachusetts laws, the Court of Appeals found that only patients committed under the third definition of "likelihood of serious harm" found in the Massachusetts mental health statute, M.G.L. c.123 §1, could be considered to have been committed under the state's parens patriae power. (App. at p. 19a-23a.) It then notes that the commitment of patients under the first two statutory definitions of "liklihood of serious harm" would not provide any

> adjudication of a "judgmental incapacity; since commitment under those two definitions is based solely on a police power determination of risk of physical harm to the individual or to others." 634 F. 2d at p. 658. (App. at p. 21a.)

The Court also noted that no members of the plaintiffs' class had been nor could be

identified as committed under either the first, second or third definition of the statute, and therefore there was no specific, systematic means to identify those who could be even inferentially considered as incapacitated, because they were committed under the state's parens patriae authority. 634 F. 2d at p. 658. (App at p. 21a.)

5. The Primary Purpose Of Massachusetts' Parens Patriae Commitment Is To Care For Those Who Are Unable To Care For Their Basic Needs While In The Community.

A committing court in Massachusetts may commit a person to a mental hospital if it determines that a person is mentally ill and that there is a likelihood of serious harm if the person is discharged or allowed to remain in the community. M.G.L. c.123, Section 7 and 8 (App. at p. 188a-191a.)

In Massachusetts patients are committed pursuant to the parens patriae power, under the third statutory definition, if they are

unable to care for their basic needs in the community, i.e., to feed, to clothe or to protect themselves adequately outside a hospital environment because of their mental illness. M.G.L. c.123 §1 (App. at p. 182a-185a.)

By committing the patient, the state is overriding the person's failure to seek hospitalization voluntarily, and his objection to being hospitalized in order to have his basic needs cared for.[17] This is consistent with the historic reasons why patients have been committed under the parens patriae power, for protection of individuals from harm threatened by their remaining in

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[17]The statutory language never says or suggests that these patients are incapable of making treatment decisions once in the protective hospital environment. See Roe III, supra. Certain commentators, though, have argued that any state law which permits commitment, under parens patriae, without a specific adjudication of incompetency, is unconstitutional. See "Developments" at p. 1207-1222.

the community. Chief Justice Burger, in his concurring opinion in O'Connor v. Donaldson, 422 U.S. 563, 583, 95 S. Ct. 2486, 2497, 45 L. Ed. 2d 396 (1975) indicates that providing patients with treatment in mental hospitals is "of very recent origin." Therefore, it is inaccurate for the State to argue that treatment is the historic objective of the parens patriae commitment power.

In fact M.G.L. c.123 §§8 and 9(b) require the discharge of patients who are no longer dangerous, even if they remain mentally ill and in need of treatment. (App. at p. 189a.) (See also Addendum.)

By adopting the defendants' duty to treat' argument, those patients for whom hospitalization serves primarily a maintenance rather than a curative function would have to be released, because the Constitutionally mandated purpose for their involuntary hospitalization cannot be

satisfied.[18] The fact that some individuals who cannot be treated effectively can still be committed demonstrates that the primary function of commitment in Massachusetts under parens patriae is to care for the basic needs of the patients unable to provide those needs for themselves outside the institution.

6. The Doctors' "Duty To Treat" Argument Would Require This Court To Find That Patients Have A Right To Treatment Which They Cannot Waive.

The doctors' argument that the state has a Constitutional duty to treat all involuntarily committed patients, whether committed under the state's police power or its parens patriae power, also presumes that patients have a Constitutional right to treatment which they cannot waive. In order for this

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[18]The American Psychiatric Association admitted at fn. 7, p. 9 of its brief that hospitalization for some patients basically serves a custodial or maintenance function. See also O'Connor v. Donaldson, supra, 422 U.S. at 583, 95 S. Ct. at 2498. (Burger, CJ, Concurring.)

Court to adopt the doctors' argument that they are legally obligated to provide forced treatment to involuntarily committed patients, it must find that there is a Constitutional right to treatment, and, unlike other Constitutional rights, patients may not waive that right. Johnson v. Zerbst, 304 U.S. 458, 69 S. Ct. 1007, 93 L. Ed. 2d 1274 (1938), Brady v. U.S. 397 U.S. 747, 748, 90 S. Ct. 1463, 1468, 25 L. Ed. 2d 747; (1970); see also Rogers v. Okin, supra, 478 F. Supp. at p. 1368 (App. at p. 95a); and Davis v. Hubbard, supra, at p. 938, n. 32. As the District Court in this case declared:

> The state has a duty to make treatment available. It has no duty to impose treatment on a competent involuntary patient who prefers to refuse medication, regardless of its potential benefit. (emphasis in original) 478 F. Supp. at p. 1370. (App. at p. 101a).

The doctors also seem to assert that there are no Constitutional limitations on a doctor's ability to forcibly treat an involuntary patient, no matter how intrusive, or

dangerous, as long as the state hospital patient could not prove the practice constitutes malpractice. According to this argument, if a doctor believes that it is appropriate to use psychosurgery and electroshock he may do so regardless of the feeling of the patient.[19]

7. In Determining Whether The State Can Constitutionally Forcibly Medicate Under The Parens Patriae Power Without A Judicial Determination Of Incompetence, The Court Should Also Carefully Consider The Risks Of Forced Drug Treatment.

In determining if the state has a

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[19]Dr. Brill, the defendants' primary witness to support its position on the use of forced drugs, testified he believed it was appropriate to use psychosurgery on certain patients. TR 57-116-117. In Price v. Shephard, 397 Minn. 250, 239 N.W. 2d 905, 911 (1976), the Minnesota Supreme Court ruled that in order to involuntarily administer intrusive forms of treatment such as psychosurgery and electroshock on committed patients, Minnesota law would require an adversary court proceeding to determine if treatment is to be authorized, even though committed patients are deemed incompetent to make treatment decisions under Minnesota law. Massachusetts considers anti-psychotics as intrusive. Roe III, supra.

compelling interest in forcibly medicating competent patients under the parens patriae power, the Court should take into account the high risk of adverse physical, intellectual and emotional damage caused by anti-psychotic drugs and the limitations of these drugs in terms of expected prognosis, as described previously in the brief, as well as consider what additional risks occur when the drugs are used involuntarily.

The District Court in Rogers v. Okin, 478 F. Supp. at p. 1361, when addressing the right not to be forcibly treated with anti-psychotics, recognized the need to treat patients with anti-psychotic drugs voluntarily.

> Indeed, a fundamental concept for treatment of the mentally ill is the establishment of a therapeutic alliance between psychiatrist and patient. Implicit in such an alliance is an understanding and acceptance by the patient of a prescribed treatment program. (App. at p. 74a.) (See also PF ¶243-245, 248.) (App. at p. 169-171.)

Consistent with that finding is Chief Justice Burger's statement in his concurring opinion, O'Connor v. Donaldson, supra, 422 U.S. at p. 583, 95 S. Ct. at p. 2498.

> Similarly it is universally recognized as fundamental to effective therapy that the patient acknowledge his illness and cooperate with those attempting to give treatment, yet the failure of a large proportion of mentally ill persons to do so is a common phenomenon.

The adverse impact of involuntary drug treatment was specifically addressed and recognized in both Rennie v. Klein, supra, 462 F. Supp. at 1141 and in Davis v. Hubbard, supra at p. 936, 937. The District Court in Rennie v. Klein, supra, at p. 1141 stated that:

> ...a trusting relationship or therapeutic alliance between psychiatrist and patient is essential for a drug regiment to succeed. Plaintiff has demonstrated psychotropic drugs are less efficacious in a hostile or negative environment. As a corrollary to this, even if the best drug is prescribed, if the patient is unwilling to accept it, the positive effects are greatly lessened, especially in terms of long range benefits. (citations to transcript and cases depleted).

In addition, the fact that Massachusetts encourages the use of voluntary admissions to its mental hospitals, M.G.L. c. 123 §10, 11 and 12(c), is evidence that the Massachusetts legislature views voluntary treatment as more beneficial than involuntary treatment. (App. at p. 16-18, 28, 63a-64a.)[20] (See also PF # 239-265.) (App. at p. 167-174.)

In addition, a basic principle of psychiatric training and psychiatric practice provides that a patient should not be involuntarily medicated in non-emergency situations. "Sovner, et al", supra, (See

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[20]Consistent with that interpretation is the decision in Goedecke v. State of Colorado Department of Institutions, supra, at p. 125. The Colorado Supreme Court found that the statutory language "to encourage the use of voluntary rather than coercive measures to secure treatment and care for mental illness" supported their conclusion that Colorado law protects involuntary patients from involuntary non-emergency medication.

finding #261-263.)[21] (App. at p. 174-176.)

V AS A MATTER OF STATE AND CONSTITUTIONAL LAW THE COURT OF APPEALS WAS CORRECT IN REQUIRING A JUDICIAL PROCEEDING FOR A DETERMINATION OF INCOMPETENCY TO MAKE TREATMENT DECISIONS.

A. Massachusetts Law Requires Judicial Proceedings Before A Determination Of Incompetence Can Be Made.

The Defendants argue that a court adjudication of incompetency is not Constitutionally required; that a formal hearing is more than is "due" under the procedural protections of the Fourteenth Amendment. They cite the Supreme Court's recent decision in Parham v. J.R., supra. However, the Court of Appeals' opinion does

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[21]The authors of this article include Dr. Randolph, the direct supervisor of Dr. Gill, (the superintendent of the Austin Unit) and the superintendent of the Bay Cove Mental Health Center, the umbrella organization over the Austin Unit; Dr. Albert DiMascio, the Director of the Massachusetts Department of Mental Health Psychopharmacology Department and Dr. Robert Sovner, the Director of one of the units at Boston State Hosptial not involved in the lawsuit. (PF # 228.) (App. at p. 164.) P-DiMascio TR 29-7-9; P-Sovner TR 70-3, 4, 7, 50.

not attempt to elevate the state incompetency procedure to a Constitutional level. It merely points out that Massachusetts has an exclusive procedure for assessing and for dealing with persons felt to be incompetent to manage their own affairs. 634 F. 2d at p. 659. (App. at p. 23a-24a.) Parham clearly permits a state to provide greater procedural protection than might be required by the Constitution. Parham, supra, 99 S. Ct. at p. 2507. Neither party argues that the Massachusetts incompetency scheme is unconstitutional on its face or as applied here. Most of the defendants' complaints about alleged delay, extra cost and its inappropriateness for mental patients may be, if accurate, the proper subject of debate in the Massachusetts legislature responsible for creating this procedure.[22] The plaintiffs

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[22]It should be noted that the defendants do not dispute the appropriateness of using these procedures when dealing with medical and surgical decisions.

believe that the lower courts did not have the power to ignore the state incompetency procedure, once it concluded that issues of competency are involved. Even assuming there are a variety of better ways to decide the competency of mental patients, which the plaintiffs will address in the next section, the federal courts can hardly choose to disregard the approach selected by the state.

This Court may consider whether, as a matter of state law, judicial incompetency procedures apply to involuntarily committed mental patients rather than whether they should apply. The District Court and Court of Appeals interpreted Massachusetts law to

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In those cases in which patients go in and out of competency, as the defendants claim, the substituted judgment procedure, as outlined by Roe III, supra, should satisfy any concerns the doctors have. Only one hearing is necessary to determine what the person, when incompetent, would do if competent.

require a judicial hearing prior to treating a patient as incompetent to make their own treatment decisions. This decision was consistent with Roe III, supra, M.G.L. c.123 §25, and D.M.H. Reg. 221.02. (App. at p. 23, 193a-194a.)

B. Even If Massachusetts Law Does Not Require A Judicial Determination Of Incompetency, This Procedure Is Required By The Due Process Clause Of The Constitution.

In order for the state to impose drugs on an unwilling patient under the parens patraie power, the patient must be unable to make rational decisions about that treatment or else the justification for substituted decision making is not present. Roe III, supra. The question for the Court is what procedures are Constitutionally required for a determinaton of incompetency, if state law does not apply.

In Mathews v. Eldridge, 424 U.S. 319, 335, 96 S. Ct. 893, 903, 47 L. Ed. 2d 18 (1976) this Court stated that

> "identification of the specific dictates of due process generally requires consideration of three distinct factors. First the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards, and finally the Government's interests, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail."

1. The Private Interests To Be Affected Are Substantial.

Forcibly medicating patients without an adjudication of incompetenece stigmatizes a mental patient as an incompetent without due process of law. See Wisconsin v. Constantinea 400 U.S. 433, 91 S. Ct. 507, 27 L. Ed. 2d 515 (1970). In Dale v. Hahn, 440 F. 2d 633 (2nd Cir. 1971) the Court of Appeals specifically characterized incompetency as a stigma. See also McAuliffe v. Carlson, supra, at p. 905; Vecchione v. Weghemuth, supra. Forced drugging also encroaches on the fundamental right to make private, important treatment

decisions and the right to be free from intrusive and potentially dangerous drugs a patient does not want.

2. There Is A High Risk Of Erroneous Deprivations Of Patients' Interests. There Is Also Substantial Value In A Judicial Rather Than A Hospital Doctor's Determination Of Incompetency.

The doctors argue that they, rather than the state courts, should determine patient's competency to make treatment decisions. They argue that it is "basically a medical decision," (Defendants' brief at p. 77) that if the decision is incorrect a patient may file an individual action "challenging the propriety of the treatment" (Defendants' brief at p. 78), that present procedures are adequate (Defendants' brief at p. 68-70), and that there is no record of past abuse which would require judicial determinations of incompetency (Defendants' brief at p. 79).

First, the defendants are seeking to change present state procedure, rather than the plaintiffs. They request this Court to

permit a hospital doctor rather than the state court to determine the patient's legal competency to make treatment decisions. Nowhere in Massachusetts is this allowed to occur.

This Court has said in Vitek v. Jones, supra, 445 U.S. at 495-496, that merely because a judge is not trained to make medical diagnoses, "[t]he medical nature of the inquiry does not justify dispensing with due process requirements." Certain due process procedures, including an adversary hearing, are Constitutionally required even if a doctor believes a transfer from a prison to a mental hospital is medically necessary. See also Parham v. J.R., supra, 442 U.S. at 607.[23]

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[23]The decision in Parham, in fact, substantially relied on the historic right of parents to have power over the health and well-being of their children. The role of parents, acting like guardians for their children's interests, was crucial for the outcome of Parham. (See concurring opinion of Justice Stewart). The doctors in the case

Secondly, the standard for competency to make treatment decisions has always been considered a legal, rather than a medical determination in Massachusetts as elsewhere and therefore requires judicial decision making. Roe III, supra, at p. 1000-1001. (See also fn. 10 at p. 70 of brief.)

In In Re K.K.B., supra, at p. 751, the Oklahoma Supreme Court, in finding a right to refuse antipsychotics, stated:

> [I]n a society ruled by law, social action that infringes or controls individual freedoms must be judged by legal standards. [L]iberty includes the freedom to decide one's health. This principle need not give way to medical judgment."

See also Rennie v. Klein, supra, F. 2d slip op. at p. 21, 22.

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at bar have no such historic right. (See concurring opinion of Chief Justice Burger in O'Connor v. Donaldson, supra, which discusses the fact that providing patients with treatment in mental hospitals is "of very recent origin." 422 U.S. at 583, 95 S. Ct. at 2486.

Furthermore, since due process requires a specific substantive standard for decision makers, it is important to note that there are no recognized medical standards for competency to make treatment decisions, nor has there been any standard consistently applied by the medical profession. See Roth, "A Commitment Law for Patients, Doctors and Lawyers," 136 Amer. J. Psychiat. 1121, 1122 (Sept. 1979).

In addition, it is highly relevant that the procedures utilized by the defendants, prior to the District Court's TRO, never involved a determination of incompetency. Prior to the District Court order if doctors believed treatment was necessary, it was forced on the patient without a court hearing, whether he/she was functionally competent or incompetent. (PF # 203, 210, 223-224a.) (App. at p. 152, 154-155, 162-163.) Therefore the defendants do not have sufficient empirical evidence to make the claim

that their past practice demonstrates that their future decision making will not create a high risk of erroneous or arbitrary results.

In fact the risk of erroneous or arbitrary decision making is especially high, because the defendants themselves admit that treatment decisions have been and will continue to be affected by the perceived needs and intersts of other patients. (Defendants' brief at p. 74-75.) Certainly the procedure the defendants suggest does not comport with fundamental precepts of due process; a fair and impartial determination of competency to make treatment decisions. See Goldberg v. Kelly, supra. (See also other reasons why the risk of arbitrary or erroneous decisionmaking is high in this brief at p. 127-132.)

The right to sue in individual actions would not adequately protect patients from forced treatment they do not want. Loss of the right to make this important treatment decision can not be measured in monetary

terms. Secondly, mental patients cannot succeed in a suit against their doctor for an erroneous decision unless they prove that the decision was made negligently or in bad faith. (App. at p. 32a-36a, 133a-139a, 142a-147a.)

3. The Governmental Interests Are Adequately Satisfied By Judicial Determinations Of Incompetency.

The state legislature and the state courts have considered and have adopted a procedural scheme requiring a judicial determination of competence and judicial involvement in intrusive psychiatric treatment, procedures the defendants claim are unnecessary, too costly, administratively burdensome and counter therapeutic. The parties in this case intervened in Roe III. See Roe III, supra, at p. 982. These procedural arguments were presented by the defendants and were rejected by the Supreme Judicial Court. Roe III, requires judicial determinations of

"competency,"[24] and substantial judicial involvement in medical decision making where the forcible use of anti-psychotics are involved. See also Superintendent of Belchertown v. Saikewicz, supra, which the Supreme Judicial Court in Roe III relied upon and which involved an institutionalized patient.

Roe III, supra, states that courts in Massachusetts can, if necessary, hear cases concerning competency to make treatment decisions in a matter of hours. Roe III, supra, at p. 1008.

The statutory procedures for the appointment of guardians are designed to accommodate emergencies and to reduce to a minimum the actual time required of psychiatrists. See M.G.L. c.201 §7, 14 and Rule 29B of the Massachusetts Probate Court Rules. (See Addendum)

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[24]Equal protection implications of treating the non-instiutuionalized and institutionalized mentally ill differently would be raised if the Roe III procedures and substantive rights were not applied. See Eisenstadt v. Baird, 405 U.S. 438, 92 S. Ct. 1029, 31 L. Ed. 2d 349 (1972).

The state may argue that the provision of guardians for indigent wards may result in some additional expense for the state or county in which the patient resides. However, it should be noted that courts, not guardians are required to make such decisions under state law. Roe III, supra. In addition, any additional cost for a procedure required by state law is the state's decision, and not that of the federal government.

VI INCOMPETENT PATIENTS HAVE A CONSTITUTIONAL AND STATE LAW RIGHT TO REFUSE ANTI-PSYCHOTIC DRUGS.

A. The Supreme Judicial Court Reaffirmed In Roe That In Massachusetts Incompetent Persons Have A Common Law Right To Refuse Anti-Psychotic Drugs.

The Supreme Judicial Court in Roe III, supra, reaffirmed that incompetent persons also retain the right to refuse anti-psychotics under Massachusetts law. As the Court stated,

> "to deny the right to persons who are incapable of exercising it personally is to degrade those whose disabilities make them wholly reliant on other more fortunate, individuals." Roe III, supra, at p. 1001.

B. The Court of Appeals Was Correct When It Held That Incompetent Persons Have A Constitutional And State Law Right to Refuse Anti-psychotic Drugs.

The Court of Appeals declared that

> "[f]ollowing a determination of incompetency, state actions based on paren patriae interests must be taken with the aim of making treatment decisions as the individual himself would were he competent to do so."

citing to a Massachusetts Supreme Judicial Court case, Superintendent of Belchertown State School v. Saikewicz, supra, at p. 742, for its holding. See also In The Matter Of Spring, 405 N.E. 2d 115, 121, 159 (Mass. 1980); Roe III, supra, at p. 1011-1012, 1017, fn. 20.

The Supreme Judicial Court in Roe III stated that:

> If the judge feels that the "best interests" of the ward demand one outcome but concludes that the ward's substituted judgment would require another, then in the absence of an overriding State interest, the substituted judgment prevails. In short, if an individual would, if competent, make an unwise or foolish decision, the judge must respect that decision as

> long as he would accept the same decision if made by a competent individual in the same circumstances. We digress concerning this "right to be wrong" only to establish the relationship between the "best interests" standard and the substituted judgment determination. (citations omitted.)

Roe III, supra, at p. 1017, n. 20. See also Superintendent of Belchertown v. Saikewicz, supra, at p. 427, 428; Doe v. Doe, 385 N.E. 2d 495, 1000 (Mass. 1979); In re Boyd, supra, at p. 750.

In an effort to ensure that the substituted judgment test is properly applied, the Court of Appeals instructed the District Court to create appropriate procedures, including the establishment of an independent review mechanism, to review the decision maker's application of the substituted judgment test.

However, the Supreme Judicial Court has obviated the need for this Court or the District Court to create a review mechanism. The Supreme Judicial Court held that since the application of substituted judgment, a

standard which requires the decision maker to determine what the ward would have decided to do if competent, is difficult for the "most capable, detached and diligent decision maker," and since a parent or guardian would have "to ignore all but the implementation of the values and preference of the ward," Roe III, supra, p. 1009-1010, the decision of whether to authorize the forcible administration of anti-psychotic drugs to an incompetent mentally ill person under Massachusetts law is best left to a judicial decision maker to "ensure the objectivitiy which other processes might lack." Roe III, supra, at p. 1010.

The Court also noted that court involvement creates no additional burden on the judiciary since a court needs to be involved, under Massachusetts law, in the adjudication of incompetence. Roe III, supra at p. 1003-1009.

VII IN THE ABSENCE OF A THREAT OF VIOLENCE, A DOCTOR MAY ONLY FORCIBLY MEDICATE A PATIENT BELIEVED TO BE INCOMPETENT IF HE FEELS THAT THE PATIENT'S MENTAL HEALTH WOULD SIGNIFICANTLY DETERIORATE DURING THE DELAY BETWEEN THE TIME THE PATIENT REFUSES AND THE MOMENT IN WHICH THE PROBATE COURT DECIDES THE ISSUE OF INCOMPETENCY.

The Court of Appeals expressed concern regarding the time involved in obtaining an adjudication of incompetence. Its concern was that during the period of delay in judicial action, the failure to medicate would cause the patient to deteriorate significantly. The Court of Appeals held that during this limited period the doctors could authorize forced medication, under the parens patriae power, without a judicial finding of incompetence. (App. at p. 24a-26a.) This limited period in which the doctors can authorize forced medication was established in order to enable the doctors to maintain the status quo pending a judicial determination of incompetence.

The Court of Appeals remanded the case

to the District Court for consideration of alternative ways to make incompetency determinations in those limited situations. 634 F. 2d at p. 661. (App. at p. 26a.)

The Supreme Judicial Court directly addressed this section of the Court of Appeals' decision. Roe III, supra, at p. 1008. Although agreeing with the Court of Appeals that a patient's interest would not be furthered by requiring doctors or other parties to stand by and watch a patient slip into chronic illness while awaiting an adjudication, it stated that in cases of actual emergenices, where there may be immediate, substantial and irreversible deterioration of a person who is seriously mentally ill, Massachusetts courts can hear a case and rule "in a matter of hours." In effect the Court held that in Massachusetts

this section of the Court of Appeals' decision is largely irrelevant.[25]

VIII THIS COURT SHOULD AFFIRM THE COURT OF APPEALS' DECISION CONCERNING FORCED ANTI-PSYCHOTIC MEDICATION UNDER THE STATE'S POLICE POWER.

Both the plaintiffs and the defendants agree that the state has a legitimate interest in protecting patients from violence. Certain deprivations of liberty may be necessary to preserve order and to protect patients from harm caused by others and from self-inflicted injury. Rogers v. Okin, supra, 634 F. 2d at p. 654-657, 478 F. Supp. at p. 1364-1370; (App. at p. 7a-15a, 82a-104a); Harper v. Cserr, 544 F. 2d 1121, 1123 (1st Cir. 1976).

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[25]The A.P.A. in its amicus brief has admitted that this type of emergency situation is rare. (APA brief at p. 21.) In addition, as was described during testimony at trial, the cessation of anti-psychotic medication generally takes approximately six days before a patient will begin to deteriorate without drugs. (Trial transcript, D-Seil, TR. 58-97, 98). The major concern expressed by the Court of Appeals is not to "treat" the patient, but to prevent "significant deterioration" during the delay before the State court can act. (App. at p. 26a.)

A. Under Massachusetts law and the Due Process Clause of the Fourteenth Amendment, Patients Committed Pursuant to the State's Police Power Should Not Be Automatically Subject to Involuntary Anti-Psychotic Medication Merely Because They Have Been Committed.

Although some of the patients in the plaintiff class, while residing in the community, were potentially dangerous, which required their isolation from society and commitment under the state's police power to a mental hospital, those same individuals do not necessarily constitute a danger or threat of danger in the institutional setting. M.G.L. c.123 §1; (App. at p. 182a-185a.)

Under state law individuals committed pursuant to the state's police power are not automatically subject to involuntary medication to prevent dangerousness in the hospital setting, because their potential to cause harm to self or others in the institution has not been established by their commitment. Roe III, supra, at p. 1019, n. 23. Since commitment under the police power is only a finding that

the person would present a potential to cause harm if he remained in the community and is not a ruling or factual finding that the committed person has the potential for dangerousness in the hospital setting, Constitutional due process requires that before anti-psychotic drugs are forcibly administered to prevent violence, an independent, individualized assessment of the patient's potential for violence in the institutional setting must be made. To conclusively presume that a particular patient committed under the police power has the potential for causing harm in the hospital merely because of his commitment would violate Massachusetts law and Constitutional due process.[26]

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[26]The defendant, Dr. Gill testified that 20-25 percent of the patient population had so-called "dangerous propensities", although they did not pose a substantial threat of physical harm and they have never committed a violent act. Only 3-5 percent of patients commit violent acts. (App. at p. 100a.)

Roe III, supra, at p. 1019; Cleveland Board of Education v. Lafleur, supra; McAuliffe v. Carlson, supra.

In addition, as the Court of Appeals noted, as a practical matter it is impossible to identify those members of the plaintiffs' class who were committed under the state's police power rather than under the state's parens patraie power and who could therefore be presumed to have been committed for dangerousness. (App. at p. 20a, 21a.)

B. Pursuant To The State's Police Power A Doctor, In Certain Circumstances, May Forcibly Administer Anti-psychotic Drugs To A Competent Patient To Serve The Societal Interest in Preventing Violence.

If the state may not automatically

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(See D-Gill, TR. 11-152 (PF #29.) (App. at p. 288.) This testimony is consistent with all the medical and legal literature which agree that mental patients are no more dangerous than the general population. See "Developments" at p. 1230, n. 157-158.

forcibly medicate patients under the state's police power for dangerousness merely because he is committed, it is necessary to determine the standards to be applied when forced medication is used for this purpose.

Both parties agree that the state's interest in preventing violence is sufficient to justify, in certain situations, the forcible administration of anti-psychotic drugs to presently 'dangerous' patients, even if they are deemed competent to make their own treatment decisions.

In those circumstances in which the doctor seeks to preserve institutional order and to prevent violence, the doctor's obligation to protect all of the patients on the ward may require sacrificing the interests of the individual patient by forcibly medicating him even though the individual's treatment needs not be served by the forced injection of anti-psychotic drugs. See Rogers v. Okin, supra, 478 F. Supp. at

p. 1361; Rennie v. Klein, supra, 462 F. Supp. at p. 1131.

The Supreme Judicial Court of Massachusetts recognized this fact when it held that when anti-psychotics are used pursuant to the state's police power

> The character of the government intrusion then changes. The primary purpose of the treatment is not to implement the substituted judgment of the incompetent, nor is it intended to administer treatment thought to be in [the patient's] best interest. It bears emphasis that public safety then becomes the primary justification for such treatment. Under these circumstances anti-psychotic drugs function as chemical restraints forcibly imposed upon a unwilling individual who, if competent, would refuse such treatment. Roe III, supra, at p. 1018.

The question is at what point can a doctor forcibly medicate to serve the societal interest in preventing or controlling violence in a hospital, and thereby override the patient's right to refuse.

C. In Its Interpretation Of Massachusetts Law, The Supreme Judicial Court Settled the Issue of At What Point A Patient's Right to Refuse May be Overridden By the State's Police Power.

The defendants claim that police power forced medication is used to treat dangerousness and not to chemically restrain patient's dangerousness. [27] This is important, because Massachusetts General Laws, Chapter 123 §21 and Department of Mental Health Regulation §223.02 specifically hold that when medication is used to restrain dangerous behavior it can only be used in

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[27]This seems to be only a semantic difference though. For example the American Psychiatric Association noted in its amicus brief that whenever drugs are used to prevent violence they act as a restraint. APA brief at p. 8 n. 7. The Supreme Judicial Court in Roe III, supra, at p. 1018, as indicated above, seems to share this position. The Department of Mental Health when it revised its regulations to clarify the rules regarding restraint, stated that any medication given to patients forcibly or involuntarily is medication which serves as a chemical restraint and therefore its use must comply with D.M.H. Reg. 223.01-223.08. Plaintiffs' Exhibit 20. D.-Gill 64-61, lines 12-21. (PF #267.) (App. at p. 179.)

cases where there is "a serious threat of or as a result of extreme violence, personal injury or attempted suicide." (App. at p. 18, 25.) This state statutory and regulatory standard is similar to the District Court's standard, which authorized forced medication under the police power, "in an emergency situation in which a failure to do so would result in a substantial likelihood of physical harm to the patient, other patients or staff members of the institution." (App. at p. 85a.)

However, the state statutory and regulatory standard is substantially more stringent than the police power standard adopted by the Court of Appeals.(App. at p. 14a.)

Neither the District Court nor the Court of Appeals directly addressed nor discussed why they were not legally bound to apply the state statutory and regulatory standard for the use of these drugs as a chemical restraint to the use of these drugs to 'treat' dangerousness.

Although the Supreme Judicial Court in Roe III, supra, did not specifically mention M.G.L. Chapter 123, §21, or D.M.H. Reg. §223.02, the Court did hold that when anti-psychotic drugs are used to protect the public safety and to prevent violence, the drugs "function as chemical restraints". Roe III, supra, at p. 1018.

The Court's decision in Roe III implicitly requires that for police power medications the state statutory and regulatory standard, rather than the Court of Appeals' Constitutional standard, should be applied. Police power medications, by definition, are used to prevent violence. Since such drug use has been held under Massachusetts law to "function as chemical restraints", the Massachusetts mental health statute and D.M.H. regulations require that medication used as a "chemical restraint" only be used "in cases of an emergency, where there is a serious threat of or a result of extreme

violence, personal injury or attempted suicide." M.G.L., Chapter 123 §21, D.M.H. Reg. 223.02. (App. at p. 18, 19, 25.)

It should be noted that the Massachusetts state legislature and the Department of Mental Health, in recognition of the type of patients residing in state mental hospitals, and the needs of those facilities, and consistent with the "highest practicable professional standards" for the "treatment" and "restraint" of the "mentally ill", established these clear standards for the use of drugs to control violence in Massachusetts hospitals. This Court should hold that Massachusetts law governs and that the state must comply with its own law. M.G.L. c.123, §1, 21. (App. at p. 184a-185a); M.G.L. c.123, §2. (App. at p. 15.)

D. At A Minimum The Constitution Requires The Affirming Of The Due Process Standards Established By the Court of Appeals To Limit The State's Forcible Administration Of Anti-psychotic Drugs To Prevent Or Control Violence.

If this Court holds that state law is not applicable to the use of drugs to prevent violence in state institutions, the Court must then determine what is the Constitutionally required standard for forcibly medicating patients under the state's police power.

Given the significant invasion of fundamental liberty interests involved when a patient is involuntarily administered anti-psychotic drugs, and the fact that the drugs are not being used to serve the individual patient's best interest, Rogers v. Okin, supra, 478 F. Supp. at p. 1361; Rennie v. Klein, supra, 462 F. Supp. at p. 1131, the Constitution requires that there be certain limitations on the state's power to

forcibly administer anti-psychotic drugs.[28] As the Court stated in another context "even when pursuing a legitimate interest, a state may not choose means that unnecessarily restrict Constitutionally protected liberty." Kusper v. Pontikes, 414 U.S. 51, 58, 59, 94 S. Ct. 303, 308, 38 L. Ed. 2d 250 (1973). See also Ingraham v. Wright, supra, 430 U.S. at 673.

E. The Standards Applied By The Court Of Appeals To Permit Forced Medication Under The Police Power Satisfy Any State Interest In The Prevention And Control Of Violence.

When determining what Constitutional standard to apply this Court must balance the

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[28]The defendants admit that the decision to forcibly medicate is not made to protect the interests of the individual patient but to protect the interests of all the patients and staff at the state hospital." (Defendants brief at p. 75.) The American Psychiatric Association maintains that drugs given to prevent or control violence or for any other purpose than the patient's best interest are inappropriate, against prevailing practice norms, and subject to great abuse. (APA brief at p. 20 n. 18, p. 11, n. 9.) The APA maintains that the state's police power can be satisfied without the use of anti-psychotic drugs.

patient's right with the needs and exigencies of the hospital community. See e.g. Wolff v. McDonnell, supra, 418 U.S. at 536.

Recognizing both the strong patient and state interests involved in the use of forced anti-psychotic medication to prevent violence, the Court of Appeals held that the treating doctor must balance the possibility, nature and type of violence with the likely effect that the drugs will have upon the particular patient. The Court of Appeals stated that a doctor may administer anti-psychotic drugs under the police power as a

> "result of a determination that the need to prevent violence in a particular situation outweighs the possibility of harm to the medicated individuals... Additionally reasonable alternatives to the administration of anti-psychotics must be ruled out...

Since it is recognized that anti-psychotic drugs can substantially alter or blunt a patient's thoughts and emotional processes, and since the use of medication to control violence "undermines its treatment

efficacy and is subject to great abuse" (APA brief at p. 20, n. 18) and since other forms of chemical and non-chemical means of restraint are available to the state to protect the safety of patients and maintain institutional order,[29] the Court of Appeals could have reasonably ruled that the use of drugs for this purpose is Constitutionally

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[29]The American Psychiatric Association states in its amicus brief that anti-psychotic drugs should never be used to control violence and that "[o]ther forms of intervention, such as physical restraint or seclusion, are indicated when a patient is uncontrollable". (APA brief at p. 20, n. 18.)

The evidence in this case demonstrated that there are many methods available to the state to preserve order and to protect patients from harm. These include seclusion, physical restraints, having a staff member stay with the patient in a quiet part of the ward, called specialing, use of quiet rooms, separation of the patient from the ward, and transfer to a more secure setting, Bridgewater State Hospital. Another method for preserving the institutional order in an emergency is the use of less powerful drugs, including barbituates and minor tranquilizers. The defendants, as part of an agreed statement of facts in this case, stipulated that it is good practice to utilize less restrictive alternatives prior to forcibly medicating patients with anti-psychotic drugs. (See PF # 284.) (App. at p. 184-185.)

prohibited or it could have limited the state's power to forcibly administer anti-psychotic drugs to circumstances in which there was clear and present danger of substantial harm occurring. See Mathews v. Eldridge, supra, 424 U.S. at 335. This standard is similar to the standard utilized in cases in which the state seeks to override First Amendment rights. See e.g. Edwards v. South Carolina, 372 U.S. 229, 235, 83 S. Ct. 680, 9 L. Ed. 2d 697, (1963); Brandenberg v. Ohio, supra, 395 U.S. at 447.

For example, the District Court in the case at bar and other courts have applied a stricter standard than the standard applied by the Court of Appeals.

The trial court heard the testimony of numerous experts and defendants, who testified that it was good practice, and did not impede hospital administration to restrict forced drugging of patients to cases of physical emergencies. (PF # 239-264.)

P.R. 1-59.) (App. at p. 167-176, 247-264.) Based on this evidence, the District Court held that a physician, in the exercise of his or her professional judgment, had the authority to forcibly medicate a patient in an emergency situation in which "a failure to do so would result in a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution." (App. at p. 85a.) In Davis v. Hubbard, supra, at p. 934, 935 the District Court of Ohio, after a prolonged trial, which included substantial psychiatric expert testimony, held that before drugs are used under the police power the circumstances must be "sufficiently grave and imminent to permit their coerced use." There must be the present existence of danger. "[I]t is not enough that the patient has at some time been violent." The Supreme Court of Oklahoma in In re K.K.B., supra, 600 P. 2d at p. 751, adopted the Massachusetts District Court's definition of an emergency.

The Massachusetts legislature and Department of Mental Health have also implicitly agreed with the District Court that the state's interest in institutional security can be met with a standard for chemical restraint in an emergency similar to the District Court's standard. M.G.L. c.123 §1, 21; DMH Reg. #223.02. (App. at p. 18, 25, 182a-185a.)

The defendants have appealed from the Court of Appeals' standard, which provides them substantially more discretion to forcibly medicate to prevent violence than the state mental health statute, their own Regulations, and the District Court order. The state doctors seem to demand no less than the right to have unbridled discretion in making decisions to forcibly drug patients, without review, pursuant to the state's police power. They oppose any approach which would require standards or due process safeguards to protect against the risk of

arbitrary or erroneous decisions. But see Mathews v. Eldridge, supra, 424 U.S. at 335. The substantial risk of arbitrary or incorrect police power determinations is apparent when one scrutinizes the context in which these decisions occur.[30]

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[30]The Supreme Judicial Court of Massachusetts in Rae III, supra, at p. 1004, 1005 found that anti-psychotic drugs have been "used by some doctors intentionally for disciplinary purposes," or inappropriately as a result of professional ignorance or inadequate resources, "and that among the most important reasons for their continued use is to control behavior." In Goedecke v. State Dept. of Institutions, supra, at p. 124, the Supreme Court of Colorado recognized the drugs "behavior modifying capacity." In Rennie v. Klein, supra, 476 F. Supp. at P. 1299, the medical director of one state hospital stated in a memo that the hospital "uses medication as a form of control and as a substitute for treatment." The court found that the "pattern of drug usage appears to be no different than that of other large state institutions." The court found that one patient was given anti-psychotics which often blunted her consciousness to such an extent that she would spend much of the day sleeping. Heavy doses of these drugs were "given in response to her quarrel-someness with staff caused by the fact that she felt unneeded and idle on the ward and was sometimes subject to physical assault by attendants." 467 F. Supp. at p. 1301.

The plaintiffs do not question the doctor's obligation to protect all of the patients on the ward, even if it means sacrificing the interests of one patient, as long as there is an actual threat of violence present. However, the point here is that because of this conflict in responsibility, a doctor cannot be provided unbridled discretion, without standards or procedural protections for the patient. Not only is the doctor's individual loyalty to a patient diminished by this competing concern for the entire ward, but the loyalty is also reduced by staff pressures to maintain "peace and tranquility" on the ward at the cost of individual patients. (See PF #88-91.) (App. at p. 155-157.)[31]

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[31]For example according to the defendant Goodman when he began his psychiatric residency on the May Unit on January 6, 1975 he questioned whether Willie Wadsworth should remain in seclusion (he was in seclusion since December 25, 1974). Some of the staff demanded and "threatened" that Dr. Goodman keep the plaintiff Willie Wadworth in his seclusion room. (Dr. Goodman TR. 24-2, 24-61).

The inability of doctors to resist staff pressure is even more acute when the doctors who make the medication decisions, as in the case at bar, are inexperienced and have little training to deal with the pressure from the staff to keep patients "manageable and tranquil."[32]

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Apparently Dr. Goodman acceded to this staff pressure and thereby, as the District Court found, continued to illegally confine Mr. Wadworth in seclusion for another seventeen days. (The District Court found that Mr. Wadworth was illegally secluded from December 30, 1974 to Janaury 23, 1975). (App. at p. 119a-121a.) (See also Proposed Findings for Willie Wadworth.)

[32]For example in the Austin Unit it was the psychiatric residents, not the supervising psychiatrist, who ordered the medication including orders for forcible medication. The residents had barely graduated medical school, yet were immediately given total responsibilty for ordering medication for patients. In addition, their supervision was only marginally adequate. Dr. Kantar, who supervised the residents in the Austin Unit, (D-Kantar, TR. 11-54, 55) supervised the residents for only an hour to an hour and a half a week, or approximately two minutes per patient. (D-Kantar, TR. 11-27, 28; 11-54, 55) (D-Szlyk, TR. 3-28, 29, 30).

A typical Austin Unit psychiatric resident was Dr. Szlyk. After graduating from medical school his

In addition, in violation of state regulations it was often the nursing staff and not the doctors who decided when and if a patient was to receive drugs to prevent or control violence without the doctor examining or observing the patient prior to or subsequent to the forced administration of the anti-psychotic drug. (PF # 265-292.) (App. at p. 177-186.) M.G.L. c.123 §21 (App. at p. 18, 19.)

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only psychiatric experience prior to arriving at the Austin Unit was his work in the Tufts New England Medical Center for a year. He treated only 2-3 patients at a time and treated only a total of 20-25 patients for the entire year. (D-Szlyk TR 2-3, 3-5, 28-30.) Upon arriving at the Austin Unit Szlyk was immediately responsible for the treatment and medication of approximately 30 patients. (D-Szlyk, TR 2-28-30.) (D-Kantar, TR. 11-62). In fact prior to taking on the responsibility of medicating thirty patients, Dr. Szlyk's supervisor, Dr. Kantar, did not review with Dr. Szlyk the patients' history, medication or prior drug response. (D-Kantar, TR. 11-63-64.)

This is the environment in which the defendants request the power to forcibly medicate under the police power with virtually unbridled discretion. The right to refuse anti-psychotics should not be considered in a vacuum.

It should also be noted that the District Court found that when the doctors utilized seclusion, another of their means to control patients under the police power, they consistently violated the procedural and substantive standards set out in the state statute and their other regulations, and secluded numerous members of the plaintiff class illegally. (App. at p. 105a, 115a, 119a-123a, 125a-132a.) (See also App. at p. 177-184.) The defendants did not appeal the District Court's findings or ruling concerning their illegal use of seclusion or the injunction the Court issued enjoining the non-emergency use of seclusion. These findings demonstrate that permitting the doctors the discretion to use control devices, whether chemical or non-chemical, without standards and review procedures, creates a high risk of erroneous decision making and abuse. (See also APA brief at p. 20 n. 18.).

In addition, specific substantive and

procedural standards for police power forced medication are particularly important, because it is well recognized that doctors are poor predictors of dangerousness, and of the severity of the threat. They often overpredict dangerousness, thereby causing many patients to be drugged under the police power without sufficient justification. See Mills, Mark, "The Right Of Patients to Refuse Pharmacotherapy; What Is Reasonable?," 8 Bull. of Amer. Acad. Psychiat. and Law, 313, 330 (1981); Davis v. Hubbard, supra, at p. 935.

Even though the Constitutional standard enunciated by the Court of Appeals requires a certain degree of medical judgment, this fact does not extinguish the patient's rights to be free from the high risk of unwarranted and unnecessary bodily and mental intrusions. As this Court stated in Vitek v. Jones, supra, 445 U.S. at 495-496 "[t]he medical nature of the inquiry does not justify dispensing with due process requirements."

F. Absent An Emergency, The District Court's Findings Of Fact, the Weight Of The Evidence And The Experience Of Other Hospitals And Jurisdictions Supports The Ruling That The State Does Not Have A Sufficient State Interest To Forcibly Medicate, Unless The Patient Is Adjudicated Incompetent.

After 72 days of trial, 8000 pages of transcript, hearing over fifty witnesses testify, mostly psychiatrists, psychologists, or other mental health professionals, reviewing thousands of pages of medical records and stipulations, and 2300 pages of post-trial briefs and proposed findings the District Court rejected the defendants' claims that the emergency standard enunciated in its TRO caused institutional chaos, caused patients to be harmed or worked oppressively against either the patients or the defendants. Although the Court of Appeals stated that the District Court "may have overlooked or misconstrued evidence of specific acts of violence occurring as a result of defendants'

difficulty in applying the Court's standard, it chastized the defendants and the American Psychiatric Association for exaggerating the difficulties and "erroneously attributing acts of violence to the strictness of the District Court's standard." 634 F. 2d at 655 (App. at p. 9a). The District Court's findings demonstrate that the Court of Appeals police power standard for forcibly using drugs provides the necessary discretion to the doctors. Yet the Court's standard does not lose sight of the need to protect patients from the high risk of erroneous predictions of dangerousness and the high risk that the drugs will be misused or abused.

The District Court found:

> "Aside from the proffered state interest in forced medication, the defendants also resist recognizing a right to refuse by challenging the efficacy of a regime of informed consent. The defendants' crystal ball foretells a tale of gloom if the standards imposed by this court's temporary restraining oder (TRO) are made permanent. Their

prediction is not borne out by the experience of that order. Although Dr. Gill expressed concern as to the impact of the TRO on effective treatment, he could identify only 12 patients out of 1,000 who refused their medication for prolonged periods between May 1, 1975 and June 23, 1977--and most of those changed their minds within a few days. None of these patients was transferred to a more secure institutional setting because of behavior problems. (App. at p. 98a-99a.) (For support of this finding see PF # 1-59.) (App. at p. 247-264.)

Should the TRO be made permanent, defendants foresee institutional settings becoming mere warehouses, characterized by increases in violence, patient apathy, length of stays and administrative problems. The evidence in this case, however, demonstrates that such a gloomy forecast is more dramatic than factual.[33] (App. at p. 99a.)

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[33]The District Court had substantial grounds for giving little weight to the testimony of the two doctors the defendants relied on to make these allegations. (See Rebuttal Findings # 1-59.) (App. at p. 247-264.) (See also D.-Seil TR 58-32, 33, 88, 89.) (D-Gill TR 63-30, 40, 104, 140.) In addition, one set of authors the defendants and the APA rely upon conclude that when their Massachusetts' hospital voluntarily complied with the District Court's emergency standard and permitted patients to refuse drugs, it "did not seriously impair their overall treatment and yielded some positive advantages," (at p. 345). Emergencies were "rare" and handled "smoothly" and the "feared epidemic of refusals did not materialize," (at p. 344). These findings, by doctors supportive of the defendants' legal position, put into serious question

The petitioners argue that the facts demonstrate that without anti-psychotic drugs they are unable to administer essential treatment to their involuntarily committed mental patients. The defendants oppose permitting competent patients to choose among various effective treatment alternatives.

However, as the District Court found:

> There are alternative methods of treating mental patients, though some may be slower and less effective than psychotropic medications. As has been pointed out, the target of plaintiffs' suit is forced injection of psychotropic

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the validity of the claimed 'harm' or 'chaos' if such a standard is made permenent. In addition, out of the twenty three patients studied who refused drug treatment, only five refused medication because of irrational perceptions stemming from their illness. Applebaum and Gutheil, "Drug Refusal: A Study of Psychiatric Inpatients," 137 Amer. J. Psychiat. 340, 345 (1980). Of course those patients would likely be adjudicated incompetent by a court. It should be noted that the hospital involved in the study was the hospital petitioner Mills co-directed prior to becoming Commissioner of the Department of Mental Health. This positive experience with the District Court's standard apparently led to his conclusions expressed in a recently published article. (See p. 142-146 of brief, supra.) The experience of this one Massachusetts hospital is no different than what occurred in New Jersey after the District Court's order in Rennie v. Klein, supra, provided patients a right to refuse anti-psychotics. See A. Brooks, "The Constitutional Right To Refuse Anti-psychotic Medications" 8 Bull. Amer. Acad. Psychiat. and Law, 179, 213 (1980). See also findings in Davis v. Hubbard, supra, 506 F. Supp. 915, 937 discussed infra.

> medication. Given a patient's refusal, other traditional means of psychotherapy and treatment would continue to be available. The fact that some doctors may feel that the use of psychotropic drugs is quicker and more effective than other available treatment does not mean that patients should not be given the option to follow a more conservative course in a non-emergency setting. (emphasis added) 478 F. Supp. at p. 1369, 1370. (App. at p. 99a-100a) (See also App. at p. 86a)

The doctors also claim that without the power to forcibly drug, they will not be able to prevent the needless suffering of patients. However, if the patient is competent, it is the patient who must weigh the suffering caused by his mental illness against the potential risks and the pain and discomfort caused by ingesting antipsychotic drugs. See Lane v. Candura, supra.

If the patient is incompetent

> "the natural desire to prevent suffering and the need of each individual to maintain and improve his capabilities are better viewed as a likely foundation of individual preference to be considered in the "substituted judgement test".

Roe III, supra, at p. 1017.

The doctors argue that the evidence

demonstrated that hospital facilities will no longer be treating facilities but instead will become caretaking warehouses if they are not provided the power to forcibly drug patients. They seem to contend that competent patients would not take these drugs unless forced to do so. Ironically, the plaintiffs and the District Court have more confidence in the patient's willingness to take the medication voluntarily. The District Court found that:

> Also to be borne in mind is that the great majority of patients have not declined their psychotropic medication during the pendency of the T.R.O. Most of those who did changed their minds within a few days. This speaks well for the confidence in a doctor's judgment that may be established given the effort to establish a strong therapeutic alliance. 478 F. Supp. at p. 1370. (App. at p. 100a.)

The doctors assert that the standards applied by the Court of Appeals force doctors to treat patients in a contrary fashion to what they believe is proper practice. Again this position ignores the great weight of the evidence and the District Court's findings.

> In analyzing defendants' prediction of doom should the TRO be made permanent, it is helpful to recall the testimony of the defendants and most of their expert witnesses to the effect that they would respect a patient's preference to refuse treatment absent an emeergency situation. In other words, although not conceding a patient's legal right to refuse treatment, the professionals' practice is to honor the refusal, except in an emergency. That testimony is inconsistent with any prediction of a chaotic institutional atmosphere if patients' wishes to refuse medication are honored. Certainly the expressed attitude of these interested professionals demonstrates that respecting and abiding by a competent mental patient's wishes concerning medication would not undermine the ethical integrity of the medical profession. (Emphasis added) 478 F. Supp. at p. 1370. (App. at p. 102a) (See also #262, 253-261, 263, 264.)[34] (App. at p. 264-271.) See also Superintendent of Belchertown v. Saikewicz, supra, at p. 426.

In addition, one of the defendants' experts admitted that the medication portion of the District Court's TRO had positive

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[34]The defendants seem to argue that this finding is clearly erroneous. They deny that the great weight of expert opinion supported this finding. But see PF # 57-225 (App. at p. 135-163.)

effects on statewide psychiatric practice. (PF # 59.) (App. at p. 400.) (D-Myerson TR 63-71, lines 6-13.) See also "Applebaum and Gutheil," supra, at p. 344, 345.

The Rogers District Court's findings were consistent with the Ohio District Court's finding in Davis v. Hubbard, supra.

> [M]any of the doctors who testified in the case indicated that patients should have a right to refuse psychotropic drugs" and "that there was testimony as to the recognition of the right to refuse in other institutions, most notably federal institutions, but nothing that would suggest that recognition of the right has had any adverse effects on the operation of the institution or on its treatment goals. 506 F. Supp. at p. 937, n. 31. (See also PF # 256a-257.) (App. at p. 173.)

Furthermore, as stated by the District Court, 478 F. Supp. at 1370, fn. 37 and in Davis v. Hubbard, supra, at p. 937, 938, this appeared to be the view of the American Psychiatric Association in 1977. See 134 Amer. J. Psychiat. (March 1977). (PF #261). (App. at p. 174.)

The doctors also argue that without the

ability to force drugs they will be unable to continue reducing state hospital populations.

However, as Dr. George Crane, a nationally-renowned psychiatrist and psychopharmacologist has stated, even though there has been rapid deinstitutionalization since the introduction of antipsychotic drugs, probably the most important explanation for the erosion of the hospital system is the administrations' failure to solve a number of chronic problems, such as inadequate staffing, low morale of personnel, and substandard psychiatric care of the mentally ill. Patients are being 'locked out' of hospitals as firmly as they were 'locked in' hospitals only a few years ago. "Crane: Two Decades", supra. (See PF # 133-137.) (App. at p. 124, 125.)

G. In a Recently Published Article the Petitioner, Dr. Mark Mills, Agrees With Many Of The Factual Findings And Legal Holdings Of The Lower Courts In This Case.

Dr. Mark Mills, the Commissioner of the Massachusetts Department of Mental Health, and the primary defendant and petitioner in this action, disagrees with and contradicts many of the petitioners' legal positions and factual assertions they have made in their brief to this Court. In a recently published article, Mills, "The Rights Of Involuntary Patients To Refuse Pharmacotherapy: What Is Reasonable?" 8 Bull. of Amer. Acad. Psychiat. Law 313 (1981) (hereinafter "Mills") Commissioner Mills outlines what he believes is a reasonable system for providing patients a right to refuse anti-psychotic drugs, in consideration of patients' psychiatric needs and legal rights and the governmental interests involved. (Id. at page 314). Prior to delineating that system, Commissioner Mills states that

competent persons should have an unambiguous right to determine their own treatment," (Id. at page 315), and that "the presence of mental illness" or any "specific diagnosis" does not even imply incompetence or the "incapacity to make informed-consent treatment decisions." He agrees with respondents that "some psychiatric patients (irrespective of diagnosis) will be competent and their treatment decisions should not only be heeded but protected." (Id. at page 315, 321, 322). He also asserts, in direct contradiction of petitioners' brief, that

> What is wrong with mental health care has little to do with the right to refuse treatment. Inequities in funding, inadequacies in training, misallocation of resources, and deficiencies in knowledge (about mental illness) all make present treatment less than ideal." (Id. at page 315).

Furthermore, Commissioner Mills asserts, unlike petitioners' position in their brief, that psychiatric treatment emergencies are "uncommon" and "rare". (Id. at page 322, 326). He defines psychiatric treatment

emergencies as those circumstances where a "rapid therapeutic intervention" is required to prevent the patient from "harming others or self". (Id. at p. 315). Although he states such emergencies are rare in psychiatry, the petitioners in their brief assert that the District Court order, (which defines an emergency similar to the one defined by Commissioner Mills), has had enormous deleterious effects on the hospital. The petitioners urge this Court to adopt an emergency standard not only broader than the Court of Appeals' standard but far broader than Commissioner Mills believes is necessary, reasonable, or consistent with accepted medical standards. (Id. at p. 322, 326.)

Commissioner Mills proposes that no patient, except for a very limited period (one to two weeks), be forcibly treated with antipsychotics, unless judicially declared incompetent. This limited period of time is to enable the patient, who doctors deem

incompetent, to be treated pending a judicial adjudication of incompetence. Once found incompetent by a court a substitute decision maker appointed by a court, would make the decision on behalf of the patient, except in cases of emergencies. (Id. at p. 324, 325, 331). Though he opposes guardians making the decision because guardians only "rubberstamp" the treatment recommendations of the physician, he also states that "allowing psychiatrists to treat without some kind of review or external affirmation would not appear to be sound." (Id. at p. 326 fn 23.) He makes clear that in his opinion "all long term involuntary treatment would be predicated on a judicial finding that the patient was incompetent to make decisions", whether the patient was committed pursuant to the state's police or parens patriae power. (Id. at p. 326.) Involuntary therapy would continue only as long as the patient's incapacity continues. (Id. at p. 329.) The

proposal by Commissioner Mills is very similar to the position of the respondents throughout the course of this litigation. Commissioner Mills also asserts that a period of one to two weeks is all that is necessary to "allow time for judicial determinations of incompetence" and "(potentially) appointment of a guardian..." (Id. at p. 327).

Commissioner Mills concludes with an admonition seemingly directed at the defendants in this action:

> The proposed system is designed to reallocate the present right-to- and right-to-refuse treatment equities. The traditional mental commitment approach--where physicians declare that the patient is ill, allege the presence of certain legal grounds and treat as clinically indicated--is thus altered to focus awareness onto the patient's capacity to consent. Ideally, such a system should increase psychiatric sensitivity to the prospective that what is best for the patient's illness is not necessarily best for the patient as a whole. (Id. at p. 331.)

IX THE COURT OF APPEALS' DECISION IS CORRECT IN REQUIRING THAT WHEN DRUGS ARE USED UNDER THE POLICE POWER, THE STATE MUST USE THE LEAST DRASTIC OR INTRUSIVE FORM OF RESTRAINT WHICH CAN' REASONABLY PREVENT OR CONTROL VIOLENCE

The defendants argue that the Court of Appeals relied on an incorrect application of the "least restrictive alternative" doctrine of the Due Process Clause when it required that "reasonable alternatives to the administration of anti-psychotics must be ruled out" before they could be used forcibly to prevent violence. All this says is that the treating physician, exercising his best judgment on the ward, should not resort to "intrusive" techniques unless they are reasonably necessary to serve the state interest at stake--prevention of violence. Jackson v. Indiana, supra. This is especially important because of the dangers of abuse when used for this purpose. (APA brief at p. 20 fn. 18.)

The Court of Appeals application of this doctrine is very different from that feared

by the defendants in this case. It does not expect judicial scrutiny of daily treatment plans or even drugs used solely for treatment purposes.

What is reviewable is whether the doctor reasonably considered and ruled out less drastic or intrusive means to prevent violence. Of course the exigencies of certain situations may limit such consideration.

It should be noted that the Massachusetts legislature has expressed a preference for physical over chemical restraints in dealing with threats of violence. If a physician is not available only physical restraints may be used. M.G.L. c.123 §21. (App. at p. 18, 19.) Furthermore, at least thirty five jurisdictions have acknowledged the least restrictive alternative doctrine in these statutes as applicable to treatment or involuntarily commitment. Rennie v. Klein, F. 2d, supra, slip op. at p. 20-21.

At issue is involuntarily-administered drugs which the trial court and the Massachusetts Supreme Judicial Court have found to be a very serious and potentially very dangerous. Roe III, supra; see also Rennie v. Klein, supra, slip op. at p. 20, 46, fn 6. The defendants' main complaint is not that they may have to consider less drastic alternative forms of treatment or restraint, which they stipulated they do as a matter of good medical practice, but they may not be able to forcibly use anti-psychotic drugs even if they determine that "reasonable alternatives" would adequately deal with the threat of violence they foresee. (PF #284.) (App at p. 184-185.) (See fn. 29 at p. 123 of brief.)

The requirement that reasonable alternatives to forced anti-psychotic drugs be ruled out is no more onerous than any other malpractice standard, expecting reasonable care. The doctor still has to make the decision, on the spot, with the resources

available to him. There is no reason to expect that this decision will be the subject of later judicial scrutiny anymore than any other decision he must make.

X THE PRINCIPLES OF FEDERALISM WERE NOT VIOLATED BY THE COURT OF APPEALS' REMAND ORDER TO THE DISTRICT COURT TO DESIGN PROCEDURES FOR IMPLEMENTING THE RIGHT TO REFUSE ANTI-PSYCHOTIC DRUGS.

The defendants argue that the principles of federalism were violated when the Court of Appeals remanded this case to the District Court to design procedures to insure that the patients' right to refuse anti-psychotic drugs would be properly implemented. (Defendant's Brief, p 104-105.)

They cite several decisions by this Court which they contend articulate principles of federalism offended by the remand order. Rizzo v. Goode, 423 U.S. 362, 378, 96 S. Ct. 598, 46 L. Ed. 2d 561 (1976); Bell v. Wolfish, supra, 441 U.S. at 561 and Parham v. J.R., supra, 442 U.S. at 615-616 (1979).

However, this is not a case like Parham where the procedures used by the defendants were satisfactory to the Court, or like Rizzo where the Defendant-supervisors were not found to have used improper procedures. Nor is it like Bell. One primary difference between Bell and this case is the private interest involved in Bell. In Bell it was a pre-trial detainee's "desire to be free from discomfort," Bell, supra,at 534. This case deals with a qualitatively different, fundamental interest in bodily and mental integrity and personal security.

The defendants correctly point out that the trial court, in dismissing the damages claims against them, found that they had acted "in subjective good faith" since they could not be expected to foresee this development in the constitutional law, and that they were not negligent, as measured by the standard of care existing prior to April 1975. However, they fail to note that they

followed procedures dramatically different from those required by state law. Indeed they are still highly critical of procedures which they are bound to follow by state law. Roe III, supra. Their argument defending their past procedures for forcibly medicating competent and incompetent patients, submitted three months after the Roe III decision, harshly criticizes state-mandated "judicial competency hearings" and the state-created guardianship procedure. (Defendant's Brief, p. 72-73.)

They also ask this Court to conclude that "[d]elays are inherent to judicial proceedings to determine competency" despite the Massachusetts Supreme Judicial Court's finding that such hearings may be had in a matter of hours. Roe III, supra.

The defendants refusal to comply with present state mandated procedures is consistent with their prior failure to heed their own procedural regulations controlling the use of

forced medication before the issuance of the TRO. M.G.L. c.123 §21; DMH Reg 223.02 (App. at p. 18, 19, 25.) (PF # 265-292.) (App. at p. 177-186.)

Although the trial court did not discuss any finding regarding the defendants' medication procedures beyond the ultimate conclusion that they were restrained from forcibly medicating in non-emergencies, it did make findings regarding the defendants' seclusion practices which may have some bearing on whether they will create and comply with their own rules in the future. (App. at p. 105a, 115a, 119a-123a, 125a-132a.)

The defendants also challenge would-be problems with the range of procedures that the District Court might adopt, although no procedures, other than those provided by state law, have been issued. They fear "ongoing federal supervision" and "the loss of flexibility" (Defendant's Brief, p. 104) without actual procedures to criticize. They have assumed the worse case to enhance their

argument. We suggest that their criticism is, at best, premature.

Unless the defendants are arguing that there are no procedures which the Constitution requires to monitor the use of forced drugging with anti-psychotic drugs, neither they nor this Court should assume that the procedures selected by the trial court would be unacceptable. Before this appeal was filed, both parties had submitted to the District Court their recommendations for the procedures to be chosen. This Court is being asked to overturn the trial court's decision before the fact. If the District Court were to develop procedures based primarily on its understanding of state law rather than construing the Constitution, the defendants' "federalism" complaint would be particularly misplaced. That is a realistic concern in light of the recent Roe III decision and the "chemical restraint" provisions of M.G.L. c.123 §21 and the state regulations promulgated by state officials to enforce

this state law. The trial court, with its considerable familiarity with the complex factual issues raised by this case during the 72-day trial, should be trusted to act with a proper respect for this Court's concerns about the limits of federal court intervention in the affairs of state officials. The Defendants ask this Court to presume the opposite.

CONCLUSION

For the reason set forth above, the respondents request that this Court affirm the judgment and order of the Court of Appeals of the First Circuit.

Respectfully submitted,

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Addendum

M.G.L. c. 201 §6

Mentally ill persons; appointment of guardian; commitment; hearing.

A parent of a mentally ill person, two or more relatives or friends of a mentally ill person, a nonprofit corporation organized under the laws of the Commonwealth whose corporate charter authorizes the corporation to act as a guardian of a mentally ill person, or the department of mental health, may file a petition in the probate court asking to have a guardian appointed for such mentally ill person; and if after notice as provided in section seven and a hearing the court finds that he is incapable of taking care of himself by reason of mental illness, it shall appoint a guardian of his person and estate. A copy of such appointment shall be sent by mail by the register to the said department. The court may require additional medical testimony as to the mental condition of the

person alleged to be mentally ill and may require him to
submit to examination. It may also appoint one or more physicians, expert in mental illness, to examine such person and report their conclusions to the court. Reasonable expense incurred in such examination shall be paid out of the estate of such person or by the Commonwealth as may be determined by the court. No guardian so appointed shall have the authority to cause to admit or commit such person to a mental health or retardation facility unless the court so authorizes such admission or commitment by its order or decree. The court shall not authorize such admission or commitment except after a hearing for the purposes of which counsel shall be provided for any indigent, allegedly mentally ill person. The court shall require the attendance of the allegedly mentally ill person at such hearing unless the court finds that there exists extraordinary circumstances

requiring his absence, in which event the attendance of his counsel shall suffice.

M.G.L. c. 201 §7

Notice

Upon such petition the court shall cause not less than seven days' notice of the time and place appointed for the hearing to be given to the alleged mentally ill or mentally retarded person, to the department of mental health, and, if the alleged mentally ill or mentally retarded person is entitled to any benefit, estate or income paid or payable by or through the United States veterans' bureau or its successor, to said bureau or its successor, except that the court may, for cause shown, direct that a shorter notice be given. No appointment shall be made without such notice to the heirs apparent or presumtive of the alleged mentally ill or mentally retarded person, including the husband or wife, if any, as the court may order. In the matter of said petition and all subsequent

proceedings relating thereto said bureau or its successor shall be deemed to be a party in interest if the alleged mentally ill or mentally retarded person is so entitled.

M.G.L. c. 201 §14

Appointment; removal; discharge; commitment; hearing.

Upon the petition of a mayor or the selectmen, the department of public welfare, the department of mental health, or other person in interest, the court may, if it finds that the welfare of a minor, a mentally ill or mentally retarded person or spendthrift required the immediate appointment of a temporary guardian of his person and estate, appoint a temporary guardian of such minor, mentally ill or mentally retarded person or spendthrift, with or without notice, and may in like manner remove or discharge him or terminate the trust. A temporary guardian may proceed and continue in

the execution of his duties, notwithstanding an appeal from the decree appointing him, until it is otherwise ordered by the supreme judicial court, or until the appointment of a permanent guardian, or until the trust is otherwise legally terminated. No temporary guardian so appointed shall have the authority to cause to admit or commit such minor, mentally ill or mentally retarded person or spendthrift to a mental health or retardation facility unless the court specifically finds the same to be in the best interests of such person and specifically authorizes such admission or commitment by its order or decree. The court shall not authorize such admission or commitment except after a hearing for the purposes of which counsel shall be provided for any indigent person subject to such admission or commitment and the court shall require the attendance of such person at such hearing unless

the court finds that there exists extraordinary circumstances requiring his absence, in which event the attendance of his counsel shall suffice; provided, however, that in cases of extreme emergency the court may authorize such admission, commitment or treatment by an ex parte proceeding, if it finds that the remedies under the emergency provisions of section twelve of chapter one hundred and twenty-three are not applicable or would not be available to deal with the present emergency. No separate petition shall be necessary for the apointment of a temporary guardian, and, except as otherwise specified herein, the procedures relative to filing, notice, hearings, and related matters normally incident to equitable proceedings and relief prior to final decree, shall apply to these proceedings, and the principles of equity normally applicable to the issuance, denial and expiration of temporary or preliminary relief and orders shall also so apply.

Whenever a temporary guardian is so appointed, the decree or order shall indicate the nature of the emergency requiring such appointment and the particular harm sought to be avoided, and shall state that the temporary guardian so appointed is only authorized to take such actions with regard to the ward as are reasonably necessary to avoid the occurrence of that harm.

M.G.L. c. 201 §16

Appointment

If a person by reason of advanced age or mental weakness is unable to properly care for his property, the probate court may, upon his petition or upon the petition of one or more of his friends, or if a person by reason of physical incapacity is unable to properly care for his property the probate court may, upon his petition or with his written assent, and in each case if after notice as provided in section seventeen and after hearing it appears that such person is incapable of

properly caring for his property, appoint a conservator to have charge and management of his property, subject to the direction of the court.

Rule 29B of the Massachusetts Rules of Probate Court

Temporary Conservatorships and Guardianships:

Written notice of a hearing on a petition for a temporary conservatorship or guardianship shall be given at least seventy-two (72) hours (Saturdays, Sundays and holidays excluded) in advance of said hearing as follows:

(1) Temporary Guardianship of a Minor:

a. To the minor, if he is above the age of fourteen; and

b. To the natural or adoptive parents of said minor; and

c. If custody of said minor has been awarded by a court of competent jurisdiction, to the person or persons to whom custody has been awarded; and

d. To the person or persons with whom said minor child is residing.

(2) Temporary Guardianship of a Mentally Ill Person and Temporary Conservatorship:

a. To the proposed ward; and

b. To the spouse and to the children who are of legal age of the proposed ward and, if the proposed ward has no living spouse nor children of legal age, to the next of kin of legal age.

A sworn affidavit of notice shall be filed with the court at or before the time of hearing of the petition. In the event that any person to whom notice is required is of parts unknown, such notice shall be delivered or mailed to that person's last known address, and the fact of such delivery or mailing shall be recited in the affidavit of notice.

If the court determines that a situation exists which requires the immediate appointment of a temporary conservator or temporary guardian, it may waive the notice requirements

hereinbefore set forth and grant the petition provided, however, that notice of the allowance of said petition is given to the person or persons hereinbefore described, stating further that any such person may move to vacate the order of the court or request that the court take any other appropriate action on the matter. A sworn affidavit stating that such notice has been given shall be filed with the court within three (3) days (excluding Saturdays, Sundays and holidays) following the date of allowance of the petition. Upon failure to file such affidavit the court may on its own motion vacate said decree. In the event that any person to whom notice is required is of parts unknown, such notice shall be delivered or mailed to that person's last known address, and the fact of such delivery or mailing shall be recited in the affidavit of notice.

The appointment of a temporary conservator or temporary guardian shall be

effective for a period of ninety (90) days from the date thereof, and each certificate of appointment issued shall have in a prominent place the following notation:

> "THE AUTHORITY OF THE -- CONSERVATOR -- GUARDIAN -- NAMED HEREIN IS LIMITED TO A PERIOD WHICH EXPIRES ON -- ."

The court may, for good cause shown, extend for additional ninety (90) day periods the appointment of a temporary conservator or temporary guardian provided the same procedure as outlined above is followed, and subsequent certificates of appointment shall bear the notation above specified with respect to the expiration of the period within which the temporary conservator or temporary guardian may act. No such extension may be granted unless an affidavit of notice has properly been filed.

No temporary appointment of a guardian or conservator will be allowed unless a permanent petition has been filed and is being prosecuted. No extension beyond the original

ninety (90) day temporary appointment will be allowed unless an inventory and bond of the temporary fiduciary has been filed.

M.G.L. c. 123 §9(b)

Any person may make written application to a justice of the superior court at any time and in any county, stating that he believes or has reason to believe that a person named in such application is retained in a facility or the Bridgewater State Hospital or the I.C.U. who should no longer be so retained, giving the names of all persons interested in his confinement and requesting his discharge. The justice within seven days thereof shall order notice of the time and place for a hearing to be given to the superintendent or medical director or director of the I.C.U. and to such other persons as he considers proper; and such hearing shall be given promptly before a justice of the superior court in any county. The

justice shall appoint an attorney to represent any applicant whom he finds to be indigent. The alleged mentally ill person may be brought before the justice at the hearing upon a writ of habeas corpus, upon a request aproved by the justice. Pending the decision of the court such person may be retained in the custody of the superintendent or medical director or the director of the I.C.U. If the justice decides that the person is not mentally ill or that failure to retain the person in a facility or the Bridgewater State Hospital would not create a likelihood of serious harm, or finds that the woman in the I.C.U. is not mentally ill; has not engaged in repeated and recent incidents of serious self-destructive behavior or assaultative behavior as an inpatient at a facility or an inmate of a place of detention; can be properly treated in any other facility licensed, operated or regulated by the department or a place of

detention in the case of a woman under sentence; and there is not a substantial likelihood that woman's condition will continue to cause her to inflict serious harm upon herself or others, said persons shall be discharged. If the justice decides that a patient at the Bridgewater State Hospital does not require strict security, he shall be transferred to a facility.

Added by St. 1970, c. 888, §4. Amended by St.1971, c. 760, §7; St.1978, c. 367, §71E.